INSTITUTIONAL CONTROL OF PHYSICIAN BEHAVIOR: LEGAL BARRIERS TO HEALTH CARE COST CONTAINMENT

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INTRODUCTION¹

A revolutionary transformation is occurring in American medicine.² After decades of uncontrollable growth, federal, state, and private initiatives are beginning to show some promise of slowing health care spending by implementing prospective payment programs on an extensive scale. These new forms of reimbursement no longer guarantee health care providers unlimited payments based on the number or cost of services the provider chooses to render. Instead, they fix

¹ The following acronyms are used throughout the article:

AMA: American Medical Association.

AHA: American Hospital Association.

DHHS: Department of Health & Human Services. "Secretary" refers to the head of this agency.

DRGs: Diagnosis-Related Groups—The reimbursement method recently adopted by Medicare, which pays hospitals a single, preset amount for each patient admitted according to the patient's diagnosis, age, and condition.

HMO: Health Maintenance Organization—A health care organization that combines insurance and treatment functions in the same entity by providing all needed care for a lump sum annual payment.

HCFA: Health Care Financing Administration—The agency within DHHS with direct responsibility over Medicare and Medicaid.

IPA: Individual Practice Association—A form of HMO that provides care through contracting physicians who maintain independent practices in their individual offices; contrast with group HMO models where physician owners or employees operate out of a clinic-based setting.

JCAH: The Joint Commission on Accreditation of Hospitals (recently renamed the Joint Commission on Accreditation of Healthcare Organizations)—A private credentialing organization with enormous influence on hospital structure and functioning.

PPS: Prospective Payment System—Another description of Medicare DRG's, one that emphasizes the fixed, preset nature of payment.

² See J. CALIFANO, *AMERICA'S HEALTH CARE REVOLUTION* (1986); Easterbrook, *The Revolution in Medicine*, NEWSWEEK, Jan. 26, 1987, at 40; Fuchs, *The Counterrevolution in Health Care Financing*, 316 NEW ENG. J. MED. 1154 (1987).

the amount to be paid in advance of treatment, or rigorously monitor the need for treatment during its course.

Health care institutions are at the vanguard of this revolution in reimbursement policy. The new programs are directed at hospitals, HMOs, and other organizations rather than at individual physicians. This fact presents an extraordinary anomaly. Physicians, not institutions, control the vast bulk of health care expenditures. Doctors determine when, how long, how intensively, and in what environment to treat patients. They order the laboratory tests, x-rays, pharmaceuticals, and surgery that determine the short-term institutional costs of treatment and that ultimately create the long-term demand for capital resources and insurance coverage.³ Although difficult to quantify with precision, informed estimates place 70 to 90 percent of health care expenditures within the control of individual practitioners.⁴

In order for health care cost containment to succeed, then, it is necessary for those institutions that employ, retain, or house doctors to implement new managerial control techniques that alter treatment behavior. Effective institutional control strategies, however, are unlikely to fit well within a legal structure that has evolved under a traditional, unrestrained reimbursement environment in which physician interests and authority have predominated.

This Article evaluates the legal controversies that institutional control of physician behavior will generate. Informed by recent works of economists, sociologists, management scientists, and organizational theorists, this analysis will reveal many hidden truths about the legal infrastructure that shapes relationships within the health care sector. Ultimately, we will learn that current cost containment programs are fundamentally at odds with the professional libertarian values of physician autonomy that are embedded in the law to preserve the practitioner's independence from the institution.

³ See Saltman & Young, *The Hospital Power Equilibrium: An Alternative View of the Cost Containment Dilemma*, 6 J. HEALTH POL. POL'Y & L. 391, 407 (1981) ("[B]eyond the impact of immediate physician ordering, there is the long-term or lagged effect upon the hospital's production base created by physicians' control over most capital costs. . . . Thus physicians exercise effective control over both the immediate and the long-term production function").

⁴ See Eisenberg, *Physician Utilization*, 23 MED. CARE 461, 461 (1985) (90 percent); Eisenberg & Williams, *Cost Containment and Changing Physicians' Practice Behavior*, 246 J. A.M.A. 2195, 2195 (1981) (50 to 80 percent); Relman, *The Allocation of Medical Resources by Physicians*, 55 J. MED. EDUC. 99, 99 (1980) (70 percent); Schroeder, *Variations in Physician Practice Patterns: A Review of Medical Cost Implications*, in THE PHYSICIAN AND COST CONTROL 23, 23 (E. Carels, D. Neuhauser & W. Stason eds. 1980) (80 percent).

I. THE IMPORTANCE OF INSTITUTIONAL CONTROL

A. *The Revolution in Health Care Financing*

For decades, medical treatment has been dominated by the Hippocratic ideal that all care should be provided that is of any conceivable benefit, regardless of the cost,⁶ which is an absurd ethic in a world of limited resources. In the mid 1980s, however, aggressive new public and private initiatives began to show dramatic potential for reining in previously unharnessed health care inflation.⁶ For the first time in a generation, health care registered single-digit inflation in 1984 and claimed a diminished portion of the GNP.⁷ Hospital sector performance was particularly impressive, with expenditures growing only 6.1 percent over 1983 levels, the slowest rate of increase in 19 years.⁸ Furthermore, in 1984 hospital lengths of stay plummeted 21 percent from 1983 levels,⁹ and occupancy rates dropped to their lowest level since the American Hospital Association began collecting such data.¹⁰

This startling improvement resulted from a number of radical new cost-sensitizing reimbursement policies adopted by federal, state, and private payers. In 1983, the federal government instituted what has

⁶ See R. VEATCH, A THEORY OF MEDICAL ETHICS 158 (1981) ("According to the Hippocratic principle, it would be immoral for a physician to take into account costs to third parties . . . in exploring the alternatives with the patient."); Angell, *Cost Containment and the Physician*, 254 J. A.M.A. 1203, 1207 (1985) ("[W]e should be prepared to argue for spending whatever is necessary for effective medical care."); Neuhauser & Stason, *Cost-effective Clinical Decision Making*, in THE PHYSICIAN AND COST CONTROL, *supra* note 4, at 133 ("Traditional clinical decision making does not explicitly assume resource scarcity. The goal of the physician is to do everything that can be done for each patient following the slogan that 'nothing is too good for my patient.'").

⁶ Since 1960, per capita medical costs have increased 1000 percent, four times the rate of general inflation. See Nexon, *Health Care Cost Control*, in HEALTH CARE AGENDA FOR THE STATES 55 (1985). See generally Wing, *American Health Care Policy in the 1980's*, 36 CASE W. RES. L. REV. 608, 618-85 (1986) (discussing the impact of rising health care costs on the consumer, the economy, and state and federal government). We now spend almost a half trillion dollars annually on health care, more than 11 percent of the gross national product. See U.S. Dept. of Commerce, *Health and Medical Services in 1988* in U.S. DEPT. OF COMMERCE, U.S. INDUSTRIAL OUTLOOK 58-1 (1988).

⁷ See Levit, Lazenby, Waldo & Davidoff, *National Health Expenditures, 1984*, HEALTH CARE FINANCING REV., Fall 1985, at 1.

⁸ See Wing, *supra* note 6, at 630.

⁹ See Philipps, Wineberg & Elfenbein, *Meeting the Goals of Medicare Prospective Payments*, 88 W. VA. L. REV. 225, 227 (1985). "Both the government and the industry have been astonished by the rapid rate of change in hospital operations since the enactment of prospective payment legislation." Iglehart, *Early Experience with Prospective Payment of Hospitals*, 314 NEW ENG. J. MED. 1460, 1461 (1986).

¹⁰ See AMERICAN HOSPITAL ASSOCIATION, HOSPITAL STATISTICS 4 (1985).

been described as health care's second "mega event,"¹¹ a prospective payment system that uses diagnosis-related groups ("DRGs") to reimburse hospitals for Medicare patients.¹² Under DRGs, hospitals are paid a fixed amount per patient regardless of treatment costs, based primarily on the patient's diagnosis. This payment system is referred to as "prospective" because the amount is objectively set in advance of treatment rather than determined after the fact by the hospital's choice of treatment.¹³ Consequently, prospective payment creates a profit/risk-based incentive for hospitals to economize.

States are also implementing increasingly rigorous controls on health care expenditures, both public and private. Some have enacted "all payer" systems that apply DRGs or other forms of prospective payment to all hospital patients.¹⁴ A greater number of states have begun to use health maintenance organizations ("HMOs") for financing and delivering health care under their Medicaid programs.¹⁵ HMOs offer comprehensive medical coverage for a fixed annual fee per enrollee, a method of prospective payment known as capitation. By combining treatment and insurance functions into one entity, HMOs inter-

¹¹ This term is attributed to health care lawyer Jack Woods. The 1966 enactment of Medicare and Medicaid is the first mega event.

¹² See Social Security Amendments of 1983, Pub. L. No. 98-21, § 601, 97 Stat. 65, (codified at 42 U.S.C. § 1395ww(d) (Supp. IV 1986)); Philipps & Wineberg, *Medicare Prospective Payment: A Quiet Revolution*, 87 W. VA. L. REV. 13, 29-30 (1984).

Medicare is the federal program that covers health care expenses primarily for the aged but also for persons who are blind, disabled, or have kidney failure. 42 U.S.C. § 1395c (1982 & Supp. IV 1985).

¹³ See Hall, *Rate Appeals Under Medicare's New Payment System: Reflections on the Meaning of "Prospectivity"*, 38 U. FLA. L. REV. 407, 418-21 (1986) (discussing the meaning and essential characteristics of a prospective system).

¹⁴ See Prospective Payment Assessment Comm'n, *Medicare Prospective Payment and the American Health Care System: Report to Congress 1987*, reprinted in Medicare & Medicaid Guide (CCH), Report No. 517, Extra Edition Pt. II, at 7 (1987) (hereinafter "ProPAC"); Schramm, *State Hospital Cost Containment: An Analysis of Legislative Initiatives*, 19 IND. L. REV. 919, 926 (1986) (9 states).

¹⁵ Medicaid is the state-operated, federally-backed program that funds health care for certain categories of financially needy. Arizona's Medicaid program is operated entirely through HMOs. See Babbitt & Rose, *Building a Better Mousetrap: Health Care Reform and the Arizona Program*, 3 YALE J. ON REG. 243, 263 (1986); Vogel, *An Analysis of Structural Incentives in the Arizona Health Care Cost-Containment System*, HEALTH CARE FINANCING REV., Summer 1984, at 13. Other states use HMOs in part of their systems. Medicare is also offering HMO enrollment as an optional method of coverage, and there are increasing reports that the administration is looking to move more in this direction in the future. See *Paying Physicians: Choice for Medicare*, Secretary's Report to Congress (Sept. 14, 1987), reprinted in [1987-1988 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 36,625, at 15,025 (1988); HOSPITALS, March 20, 1987 at 80.

Eleven states also use DRG systems in their Medicaid programs. See ProPAC, *supra* note 14, at 7.

nalize in the provider the costs of medical care.

HMO growth in number and membership is even more rapid in the private sector.¹⁶ This surge in HMO popularity is due in part to the increasing vigilance of private industry in demanding restraint in employee health insurance premium increases. Private sector cost consciousness has also fostered active experimentation with other alternative delivery systems. In response to the demands of insurance companies and self-insured employers that health care providers accept limited payment,¹⁷ hospitals and physician groups are developing a variety of delivery systems to meet the new competitive pressures.¹⁸

These three developments in prospective payment—DRGs, HMOs, and alternative delivery systems resulting from federal, state,

¹⁶ See ProPAC, *supra* note 14, at 87 (“[HMOs are] becoming available to a broader segment of the population. Forty-three states now host the headquarters of at least one HMO.”); Taylor & Kagay, *The HMO Report Card: A Closer Look*, HEALTH AFF., Spring 1986, at 81-82 (“The number of HMOs and their members have grown rapidly and continuously during the last several years.”); Wall St. J., Oct. 6, 1987, at 1, col. 1 (“In the past five years the number of [HMOs] has nearly tripled . . . and so has the number of people they cover, to about 28 million.”); N.Y. Times, July 13, 1987, at D1, col. 3 (an estimated 60 to 70 percent of physicians have contracts with HMOs).

¹⁷ See Freidson, *The Medical Profession in Transition*, in APPLICATIONS OF SOCIAL SCIENCE TO CLINICAL MEDICINE AND HEALTH POLICY 63, 69 (L. Aiken & D. Mechanic eds. 1986) (“[L]arge employers who bear the cost of health care benefits for their employees, health insurance companies themselves, and state and federal authorities have reinforced efforts to restrict the rise in health care costs by placing ceilings or ‘caps’ on what they will pay.”).

¹⁸ The most notable example is the preferred provider organization (“PPO”), a select panel of physicians or hospitals that contracts with an organization to offer its services at discounted prices in exchange for a guaranteed supply of patients. See Lissoy, Rice, Gabel & Gelzer, *Preferred Provider Organizations One Year Later*, 24 INQUIRY 127 (1987); Schwartz, *The Preferred Provider Organization as an Alternative Delivery System*, 6 J. LEGAL MED. 149 (1985). Recently, Medicare has also signalled its intention of adopting the PPO concept. See Pear, *Plan for Medicare Forces U.S. to List Approved Doctors*, N.Y. Times, Oct. 13, 1987, at A1, col. 6.

Other innovative structures that are still at an experimental or developmental stage include Primary Care Networks (“PCNs”), Exclusive Provider Organizations (“EPOs”), and HMO “wraparounds.” See, e.g., Easterbrook, *supra* note 2, at 67 (noting that Primary Care Networks “combin[e] the best elements of fixed-fee and pass-along payment. . . . PCN doctors are paid on a pass-along basis but get only 80 percent of their fee up-front. The balance goes in to a reserve for specialists and hospital admissions. At year-end any money remaining is split between the physicians”); Traska, *Plan Designs Change to Fit Choice and Cost*, HOSPITALS, Jan. 20, 1988, at 36 (“Two newer products are exclusive provider organizations (EPOs) and open-ended HMOs, sometimes known as HMO wraparounds. . . . EPOs operate on a discount basis but use a restricted group of providers, as do HMOs. . . . Open-ended HMOs allow members to seek care from non-plan physicians but provide only partial reimbursement if a member receives care outside the plan.”).

Almost 60 percent of privately insured Americans are now in “managed care” plans, defined as HMOs, PPOs, or fee-for-service plans with prospective review of hospital stays. See AM. MED. NEWS, July 1, 1988, at 4.

and private initiatives—typify the revolution that is occurring in medicine. The revolutionary impact of switching from open to closed-ended reimbursement can be expressed in a number of ways.¹⁹ Primarily, new payment methods are prospective rather than retrospective, setting the amount of reimbursement in advance of treatment rather than measuring costs or charges afterwards. By removing provider control over the amount of reimbursement, prospective payment attempts to replicate competitive market conditions in which all suppliers are “price takers.”²⁰ This objectification of payment is a common thread running throughout the variety of reimbursement innovations, which too often are discussed as disparate phenomena.

B. *The Physician/Institution Dichotomy in Prospective Payment*

A singular fact characterizes the various forms of prospective payment: each is aimed at health care institutions rather than at physicians.²¹ The DRG payment system applies only to hospitals, while Medicare continues to pay physicians on a fee-for-service basis. Capitated systems are organized around entities that represent groups of physicians who as individuals are compensated internally on different terms. Alternative delivery systems similarly are typified by innovation in institutional design rather than in the method of payment to solo practitioners.²²

¹⁹ (1) Services and departments that previously were revenue centers because they generated additional reimbursement are now cost centers because they diminish the profit margin. (2) Rather than searching for a competitive edge only by enhancing the quality of care, providers must now also engage in cost competition. (3) The new ethic in medicine to replace “do everything that can be done,” is “good value for the health care dollar.” (4) The metaphor that fit the past reimbursement structure was allowing the fox to guard the hen house because those who profited from treatment made the treatment decisions. Now, the proper analogy is to the shot-gun wedding: hospitals and physicians are forced to live together despite their fundamentally opposed financial incentives.

²⁰ See Hall, *supra* note 13, at 418-21 (discussing payment and profit/risk incentives in a prospective system). This is accomplished in greater or lesser degrees by different forms of prospective reimbursement. Capitation systems leave providers essentially no control over the amount of payment. DRG payments allow providers to determine only whether or not the patient needs hospitalization. Fee schedules control the amount charged for each unit of service but leave providers free to determine the intensity of treatment.

²¹ See Relman, *Cost Control, Doctors' Ethics, and Patient Care*, 1 ISSUES SCI. & TECH. 103, 108 (1985).

²² See, e.g., *Arizona v. Maricopa County Medical Soc'y*, 457 U.S. 332 (1982) (discussing an alternative health plan, organized by county medical societies, in which participating physicians agreed to accept pre-set schedule of fees as payment in full, to be subjected to utilization review, and to use a consolidated claims processing service, but in which physicians were still paid on a fee-for-service basis. The Court found the plan violated the Sherman Antitrust Act).

Given the physicians' central role in medicine, why has public and private reimbursement policy not targeted them more directly? There are a number of persuasive reasons. First, institutions are more efficiently regulated than individual doctors. Physician fees account for less than a quarter of health care costs.²³ The institution, therefore, is the more obvious, and less politically controversial target. The pooling that results from addressing payment schemes to institutions reduces administrative costs and spreads the risks associated with variations in patient health status over a larger patient base.²⁴

Second, it is extremely difficult to design effective regulatory controls for physicians. Institutional charges are more easily regulated because their more quantifiable cost base allows the setting of industry-wide averages. For physicians, the dominant cost input is the largely subjective value of professional time.²⁵ Additionally, defining the unit of payment in a prospective system is more manageable for institutions. Currently, the tremendous difficulty in designing DRGs that adequately fit the way in which physicians manage cases²⁶ is slowing progress toward extending Medicare reform to all providers.²⁷ Most proposals to include physicians within the DRG system would continue to allocate their fees to an institutional group—either to the hospital or to

²³ See Wing, *supra* note 6, at 629.

²⁴ See Ginsburg & Hackbarth, *Alternative Delivery Systems and Medicare*, HEALTH AFF., Spring 1986, at 6, 16 ("Per case payment for physicians, like per case payment for hospitals, would depend on high-cost and low-cost cases averaging out for any given provider. For costs to average out, a provider must have a large volume and broad array of patients, and that may pose a problem for physicians."); Ropel, *Perspectives on Physician-Payment Reform*, 319 NEW ENG. J. MED. 865, 865 (1988) ("[W]hereas hospitals can average their gains and losses under a prospective payment system across many cases, physicians' smaller caseloads and greater specialization make such averaging much more risky for them."); Sisk, McMenamin, Ruby & Smith, *An Analysis of Methods to Reform Medicare Payment for Physician Services*, 24 INQUIRY 36, 42 (1987) ("[U]nlike a hospital, which can spread financial risk over many patients, individual physicians who are paid for packages of service would be likely to bear a great deal of financial risk for severe or complex cases that require extensive services.").

²⁵ Hospital DRG rates illustrate the problems encountered in reimbursing labor costs through prospective payment. Labor is the one cost input that DRGs do not attempt to control; DRG rates are factored to account for differences in local prevailing wage rates. See 42 C.F.R. § 412.639(a) (1987).

²⁶ See Jencks & Dobson, *Strategies for Reforming Medicare's Physician Payments*, 312 NEW ENG. J. MED. 1492, 1496 (1985) (discussing advantages and disadvantages of paying physicians under three alternative DRG designs); Mitchell, *Physician DRGs*, 313 NEW ENG. J. MED. 670, 670 (1985) ("DRG payment could be a lottery, with inequitable losses for some physicians and windfall gains for other."). See generally OFFICE OF TECHNOLOGY ASSESSMENT, PAYMENT FOR PHYSICIAN SERVICES: STRATEGIES FOR MEDICARE (1986) (examining alternative methods of paying for physician services).

²⁷ See, e.g., Inglehart, *Payment of Physicians Under Medicare*, 318 NEW ENG. J. MED. 863, 868 (1988) (discussing reforms in Medicare's payment of physicians).

the medical staff as a whole.²⁸ In short, a "regulatory agency would have considerable difficulty in setting up complex physician-reward structures to produce efficient decisions on a case-by-case basis. Only within the internal organization of the hospital are such fine-tuning devices likely to be practicable."²⁹

In separating medical institutions from their constituent physicians, I am not making a technical ontological distinction based merely on the choice of a corporate form of doing business. Physicians are not the alter egos of hospitals. Doctors have carefully insulated themselves from the financial and managerial concerns of health care delivery, leaving to the lay charitable and investment community the task of creating the institutions necessary to develop and maintain the physician workplace.³⁰ As a result of this fundamental division between the practitioner and the medical institution,³¹ reimbursement policy aimed at institutions does not automatically affect physicians. Direct intervention is required to pass institutional efficiency incentives on to those who actually determine costs.³²

²⁸ See Capron, *Containing Health Care Costs: Ethical and Legal Implications of Changes in the Methods of Paying Physicians*, 36 CASE W. RES. L. REV. 708, 723-24 (1986); Firshein, *Physician Payment Plan Sparks Nationwide Uproar*, HOSPITALS, Jan. 20, 1987, at 21 (bundle all physician payments into hospital DRGs, "leaving hospitals and doctors to settle how payments would be allocated"); Ginsburg & Hackbarth, *supra* note 24, at 17 (make payments to the hospital medical staff).

²⁹ Harris, *Regulation and Internal Control in Hospitals*, 55 BULL. N.Y. ACAD. MED. 88, 98-99 (Jan. 1979).

³⁰ See E. FREIDSON, *PROFESSION OF MEDICINE*, 134-35 (1970); M. ROEMER & J. FRIEDMAN, *DOCTORS IN HOSPITALS: MEDICAL STAFF ORGANIZATION AND HOSPITAL PERFORMANCE* 25-26 (1971); P. STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 177-79 (1982).

³¹ The foundational nature of the hospital/doctor division is reflected in the parallel reimbursement structure that pervades private and public health care funding. Medicare, for instance, pays separately for institutional and physician services even when patients are hospitalized. Payment of physician services is mandated in 42 U.S.C. §§ 1395d-1395j (1982 & Supp. IV 1986) (Part A), and provision for institutional services is at *id.* §§ 1395j-1395w (Part B). For Blue Cross/Blue Shield, the name itself reflects the same division of fees. Blue Cross pays hospital expenses, while Blue Shield covers physician's and surgeon's fees. See HEALTH INSURANCE ASSOCIATION OF AMERICA, 1986-1987 SOURCE BOOK OF HEALTH INSURANCE DATA 84 (1987).

³² The need for institutional control can be seen in the legislative history for Medicare DRGs. The Secretary of Health and Human Services' Report to Congress, on which the DRG legislation was based, recognized that "the ability of a hospital to respond to prospective payment incentives depends on the ability of the hospital administrator to transmit these incentives to the attending physician staff." U.S. DEP'T OF HEALTH & HUMAN SERVICES, *HOSPITAL PROSPECTIVE PAYMENT FOR MEDICARE: REPORT TO CONGRESS* 17 (1982), reprinted in [Extra Edition No. 374] Medicare & Medicaid Guide (CCH) (Jan. 5, 1983). Implementing regulations suggest that "[r]eductions in cost per admission can be achieved . . . [by] [m]ore careful examination of the number, mix, and quality of services furnished during a patient's stay" 49 Fed. Reg. 304 (1984). Recently, the Secretary cited "evidence that hospital prospective payment . . . provides a number of . . . desired incentives by inducing hospitals to

C. *The Necessity of Institutional Control*

1. The Need to Ration Medical Care

Some observers of the health care scene contend that relatively mild measures such as education and surveillance of practice patterns will be sufficient to bring health care inflation under control.³³ A num-

control those physician services which have associated hospital costs." *Paying Physicians*, *supra* note 15, at 15. The Secretary cites as examples "decreases in hospital length of stay" and "decreases in numbers of X-rays." *Id.*

Implicit support for the notion of institutional control is equally strong. Inherent in the design of DRGs is their potential for monitoring the performance of physicians.

A central theme in the DRG literature is that the reimbursement system constrains the hospitals, and the hospitals will then seek to alter the behavior of their affiliated physicians. What is more, DRGs were designed to provide information about practice patterns that administrators would need to have in order to influence physician behavior.

Hsiao, Sapolosky, Dunn & Weiner, *Lessons of the New Jersey DRG Payment System*, HEALTH AFF., Summer 1986, at 32, 41. Originally developed at Yale University to aid in utilization review, "initial development [of DRGs] . . . resulted in part from a desire to change the ways in which . . . physicians practice in hospitals and to change the relation between hospitals and physicians." Vladeck, *Medicare Hospital Payment by Diagnosis-Related Groups*, 100 ANNALS INTERNAL MED. 576, 576 (1984). Thus, "DRG reformers believed that hospital administrators . . . would begin monitoring individual physicians' use of X rays, laboratory tests, and other services." Wiener, Maxwell, Sapolosky, Dunn & Hsiao, *Economic Incentives and Organizational Realities: Managing Hospitals Under DRGs*, 65 MILBANK MEM. FUND Q. 463, 475 (1987).

³³ See, e.g., Angell, *supra* note 5, at 1205-06 (education and surveillance will stem the tide of rising health care costs); Relman, *supra* note 4, at 104 ("Physicians do change their behavior when the scientific facts are clear enough. I believe they can learn to control excessive utilization . . .").

The reports of published trials do not support this belief in the effectiveness of physician education and surveillance. While there are many reports of successful educational efforts, these studies are plagued by methodological flaws that preclude much optimism about general reliance on education as an effective control strategy. See Eisenberg & Williams, *supra* note 4, at 2197; see also J. EISENBERG, DOCTORS' DECISIONS AND THE COST OF MEDICAL CARE 111 (1986) (noting that previous studies of the effectiveness of educational programs were not performed in controlled environments). The most disappointing flaw is the failure to monitor the long term impact of initially successful efforts to see if the effect persists. When such monitoring is done, we learn that when the intervention ceases, doctors quickly give up the ground that was gained. See Sherman, *Surveillance Effects on Community Physician Test Ordering*, 22 MED. CARE 80, 82 (1984).

Rather than instructing physicians on general principles of conservative treatment, institutions might offer specific feedback to individual physicians about their actual performance. Physician feedback has become "quite common" under Medicare DRG reimbursement through the management technique known as "physician profiling." 1 *Quality of Care Under Medicare's Prospective Payment System: Hearings before the Senate Special Comm. on Aging*, 99th Cong., 1st Sess. 330 (1985) (staff report of United States Senate Special Committee on Aging) [hereinafter "*Quality of Care Hearings*"]. There is no hard evidence of how strong a motivator these techniques will be. Past studies of physician feedback have produced mixed results. See Eisenberg & Williams, *A Controlled Trial to Decrease the Unnecessary Use of Diagnostic Tests*, 1 J. GEN. INTERNAL MED. 8, 8 (1986). To the extent that feedback is successful, it is still

ber of health policy analysts have observed a general weakening of physician power,³⁴ which suggests that doctors inevitably will fall under the influence of medical institutions. Those who contend that strong measures are not necessary point to the dramatic drop in hospital utilization that coincided with DRG implementation as evidence of physicians' willingness to cooperate with hospitals.³⁵

However, there are strong signs that the honeymoon is ending. Initial physician cooperation was prompted by the uncertainty of how hospitals would fare under DRGs and the fear that their bankruptcy or financial distress would adversely impact physicians' practice environment.³⁶ But, far from losing money, the hospital industry has profited handsomely under prospective payment. In fact, it has experienced its most successful years ever.³⁷ When physicians realize their livelihood is

necessary to inquire how long the effects persist after the intervention ceases. Most studies do not address this point. On balance, the conclusions of the more carefully designed studies are pessimistic or only cautiously optimistic about the potential for surveillance producing the type of reorientation in physicians' attitudes that is needed to reverse the forces fueling health care cost inflation. See Eisenberg & Williams, *supra* note 4, at 2195; Myers & Schroeder, *Physician Use of Services for the Hospitalized Patient: A Review, with Implications for Cost Containment*, 59 MILBANK MEM. FUND Q. 481, 501 (1981).

³⁴ See P. STARR, *supra* note 30, at 379-80, 421; COMMITTEE ON IMPLICATIONS OF FOR-PROFIT ENTERPRISE IN HEALTH CARE, INSTITUTE OF MEDICINE, FOR-PROFIT ENTERPRISE IN HEALTH CARE 175-76 (B. Grey ed. 1986) [hereinafter FOR-PROFIT ENTERPRISE IN HEALTH CARE]. With a sharp increase in medical school graduates and the proliferation of alternative practitioners, physicians' monopoly power is waning. The battle against hospital access by osteopaths has been lost and ground is slipping against physiologists, chiropractors, and midwives. See Nelson, *Report Predicts Hard Times Ahead*, HOSPITALS, May 5, 1987, at 84, 84. Governmental policy has catapulted HMOs into prominence and infused consumer interests into Blue Cross/Blue Shield governance. See 42 U.S.C. § 300e to 300e-17 (1982) (HMO Act).

The profession seems to be losing governance even over its own internal affairs. A strong campaign by the Federal Trade Commission resulted in a remarkable 1979 injunction preventing the AMA from imposing ethical restraints on a broad array of activity relating to the economics of medical practice. *In re The American Medical Ass'n*, 94 F.T.C. 701 (1979). This ruling directly resulted in the AMA's 1980 reformulation of its Code of Ethics.

³⁵ See Barry, *Medical Staff Bylaws: Protecting Hospitals' Financial Viability*, HEALTHCARE FIN. MGMT. Sept. 1986, at 40, 42 ("Generally physicians have cooperated very well with hospitals as is reflected by the two-day decline in the Medicare average length of stay in the first two years of PPS."); Hull, *Hospitals and Doctors Clash Over Efforts by Administrators to Cut Medicare Costs*, WALL ST. J., Jan. 19, 1984, at 33, col. 6 ("There are indications that doctors are cooperating . . . 'Doctors seem amazingly willing to take the long view of this thing . . .'").

³⁶ "[A]dministrators are warning that hospitals will go bankrupt without physicians' cooperation. They are telling doctors that new equipment won't be purchased if they are losing money . . ." Hull, *supra* note 35, at 33, col. 5.

³⁷ See *Hospital Profits Under the Prospective Payment System, Hearings Before the Subcomm. on Health of the Senate Comm. on Finance*, 99th Cong., 2d Sess. 29-46 (1986) (statement of B. Mitchell, Deputy Inspector General, DHHS); Office of Inspector General Memorandum, *Hospitals Continue to Earn Large Profits in the Second*

not at stake, it can be expected that they will begin to retrench and express their opposing interests more actively.³⁸

The most recent national statistics confirm this speculation. We have just witnessed a startling round of health insurance premium increases ranging from 10 to 70 percent,³⁹ spurred by 1985 and 1986 increases in health care costs much greater than the rate of inflation.⁴⁰ Despite the initial encouraging success of the new reimbursement programs, "the overall rate of increase in health care spending has not been slowed significantly by recent cost-containment initiatives."⁴¹

Following this moderation in the success of cost containment, government and private programs have become more vigilant in tightening the reimbursement screws. Hospital patient revenue margins are quickly approaching zero, and the HMO industry is also experiencing

Year of the Prospective Payment System, [1987 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 36,066 (Feb. 25, 1987); N.Y. Times, March 29, 1987, at A1, col. 3. Profits began to moderate by the third year of DRGs. See Office of Inspector General Memorandum, *Preliminary Analysis of Hospital Profit Margins in the Third Year of the Prospective Payment System*, [1988 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 36,807 (Jan. 25, 1988).

³⁸ In terms of organizational theory, physicians may "subordinate their power-maximizing strateg[ies] to the necessity of maintaining sufficient production to ensure the organization's survival," Saltman & Young, *supra* note 3, at 401, but when that survival is assured, physicians will resume their natural baseline behavior, which is to pursue strategies "to maximize [their] zone of authority within the organization." *Id.* at 400. Ultimately "the dominant group within a particular conflictive equilibrium will adjust its permanent strategy to absorb new initiatives into the existing power arrangement. In the case of the hospital power equilibrium, therefore, the physician's control over . . . the hospital's production process may well still generate sufficient resources to enable physicians to deflect any efforts to relax their decision-making grip." *Id.* at 410. The experience in New Jersey, the country's first DRG reimbursement system, confirms this speculation. See Hsiao, Sapolsky, Dunn & Weiner, *supra* note 32, at 41.

³⁹ See N.Y. Times, Jan. 12, 1988, at A1, col. 6. This article explains:

The [premium] increases . . . were especially startling because many insurers and employers were optimistic only a year ago that the explosive inflation in health care costs had been contained . . . [by] the widely heralded cost-containment efforts of the 1980s In part, the increases in premiums reflect . . . [the fact that] "[t]he health insurance industry believed that many of the initiatives it had established would be much more effective than they actually were."

Id.

⁴⁰ See Anderson & Erickson, *National Medical Care Spending*, HEALTH AFF., Fall 1987, at 98 (8.4 percent increase in 1986, compared with 1.1 percent overall inflation); Waldo, Levit & Laxenby, *National Health Expenditures, 1985*, HEALTH CARE FIN. REV., Fall 1986, at 1 (increase 5.4% above general price level of other goods and services in 1985); N.Y. Times, Feb. 9, 1987, at A1, col. 6 (7.7% increase in 1986, "seven times as fast as the Consumer Price Index"). From 1984 to 1985 Medicare payments per hospital discharge increased by nearly 12 percent. See ProPAC, *supra* note 14, at 3. Hospital lengths of stay increased for the first time since 1981. See *Inpatient Use Declines: Persistent but Slower*, HOSPITALS, Feb. 5, 1987, at 34; ProPAC, *supra* note 14, at 3.

⁴¹ Anderson & Erickson, *supra* note 40, at 103.

a sharp financial downturn.⁴² In short, any conjecture that medical institutions are out of the woods is naive. Further rounds of reimbursement cutbacks will create mounting pressure on institutions to limit services while physicians will continue to assert their independence.

Cost containment pressures will not relent until physicians have undergone a revolutionary change in behavior. The mentality of our medical establishment has produced protocols such as the "sixth stool guaiac," a sequential testing procedure for colon cancer that, upon the sixth iteration, detects only three cases per one million patients tested, at a marginal cost of \$47 million (1975 dollars) per case.⁴³ In other words, the cause of health care's financial woes is marginally productive, not unproductive, care.⁴⁴ To repeat a test six times in order to remove a three-in-one million uncertainty is not strictly unnecessary, but it is clearly wasteful.

Even the elimination of all such extravagant care would produce only a limited, one-time savings of perhaps 20 to 30 percent. Although admirable, this trimming of fat off the top of the system would do nothing about the underlying base of inflation that is estimated at seven percent annually.⁴⁵ To reach this built-in inflationary base and sustain

⁴² See Perrone, *Hospital Revenue Margins Fall*, AM. MED. NEWS, Aug. 19, 1988, at 6; Robinson, *Insurers, HMOs Hit Big Recession in '87*, HOSPITALS, Sept. 5, 1988, at 27 (three quarters of surveyed HMOs lost money in 1987); Freudenheim, *Prepaid Programs for Health Care Encounter Snags: H.M.O. Shakeout is Seen*, N.Y. TIMES, Jan. 31, 1988, at 34 (three largest HMOs reported net losses for first nine months of 1987).

⁴³ See Neuhauser & Lewicki, *What Do We Gain From the Sixth Stool Guaiac?*, 293 NEW ENG. J. MED. 226, 227 Table 2 (1975). The debate over the recommended frequency of pap smears provides another example. Gynecologists often recommend annual tests despite the fact that testing every three years produces nearly the same increase in life expectancy (104 days versus 108 days) at an aggregate cost of \$4 billion less. See N.Y. TIMES, Jan. 7, 1988, at B13, col. 3.

⁴⁴ See Havighurst & Blumstein, *Coping with the Quality/Cost Trade-offs in Medical Care: The Role of PSROs*, 70 NW. U.L. REV. 6, 19 (1975) (explaining that health care is frequently provided despite marginal benefit compared to the cost because of "[t]he variable payoff from medical care, the absence of substantial cost constraints, the wide discretion accorded physicians, and the weakness of regulatory or privately (insurer) initiated cost control mechanisms."); see also *id.* at 32 (explaining that in the health care field, the term "unnecessary care" is often used interchangeably with "overutilization," and that "much of the care falling within these categories is neither wholly useless nor affirmatively harmful," but "could be rendered effectively and appropriately in a shorter time, in a less sophisticated facility, or on an outpatient basis").

⁴⁵ See Schwartz, *The Inevitable Failure of Current Cost-Containment Strategies*, 257 J. A.M.A. 220, 222 (1987). The costs of future deployment of new medical innovations will quickly overtake any savings achieved by eliminating existing treatment of questionable benefit. In the one area of diagnostic radiology, we have seen three generations of extraordinarily expensive technology within recent memory. The use of the CAT scanner became widespread during the 1970s, magnetic resonance imaging is the brain child of the 1980s, and the still developmental PET (Position Emission Tomography) scanner awaits us in the 1990s. Other profoundly expensive procedures imple-

downward pressure on health care costs, it will be necessary to ration the resources devoted to medical treatment, that is, to withhold current and future treatment that is clearly beneficial yet is not worth the cost.⁴⁶ We will not achieve lasting control without reducing in some measure the quality as well as the quantity of care. In a system with a single-minded orientation toward "spare-no-expense" medicine, this will require a thoroughgoing change in practice styles and medical philosophy. Such a reorientation cannot begin to occur without a powerful influence on physician behavior.⁴⁷

2. Institutional Control and Physician Dominance

The slow erosion of physician dominance is consistent with the long history of professional autonomy and sovereignty that medical sociologists such as Eliot Freidson and Paul Starr have revealed.⁴⁸ For decades, physicians have enjoyed essentially unfettered control over both medical practice and its workplace. Physicians gained control of access to medical practice at the turn of the century through licensing

mented within just the past few years include skin grafts, organ transplants, artificial organs, and genetic engineering. *Id.*

⁴⁶ In addition to sources previously cited, see Morreim, *Cost Containment: Issues of Moral Conflict and Justice for Physicians*, 6 THEORETICAL MED. 257, 272 (1985) ("We will need ultimately to . . . weigh the benefits and costs of our not-so-useless medical routines. How long do patients need intensive care after an uncomplicated myocardial infarction? Under what circumstances should a physician order a third-generation cephalosporin antibiotic which can cost over twenty-five hundred dollars . . . ?"). See also H. AARON & W. SCHWARTZ, *THE PAINFUL PRESCRIPTION: RATIONING HOSPITAL CARE* (1984) (discussing the need to ration health care); Havighurst, *Health Care Cost-Containment Regulation: Prospects and an Alternative*, 3 AM. J.L. & MED. 309, 312-13 (1977) (same). See generally Evans, *Health Care Technology and the Inevitability of Resource Allocation and Rationing Decisions*, (pts. I & II), 249 J. A.M.A. 2047, 2208 (1983).

⁴⁷ If medical institutions are not allowed this control, they will be forced to coopt the legislation by exerting political pressure to seek its repeal or soften its impact. See Hsaio, Sapolsky, Dunn & Weiner, *supra* note 32, at 40. More threatening than program failure is the prospect that new financial pressures will be shunted off in counterproductive ways. "[T]here will be nothing but the ravages of excess demand unless the cost-minimizing incentive is transferred directly to the doctor part of the organization." Harris, *The Internal Organization of Hospitals*, 8 BELL J. ECON. 467, 481 (1977); see also Harris, *supra* note 29, at 88 ("If these institutional changes are not forthcoming, cost controls may produce only long queues, litigation, cream skimming, and bad medical care.")

⁴⁸ Freidson's pioneering work in the 1970s focused on physician dominance of the treatment relationship. See generally E. FREIDSON, *PROFESSIONAL DOMINANCE* (1970); E. FREIDSON, *supra* note 30. Starr's tour de force, *The Social Transformation of American Medicine*, is a broad inquiry into professional sovereignty over all aspects of medical delivery and financing. For a discussion of the social origins of professional sovereignty, see P. STARR, *supra* note 30, at 3-29. See also D. STONE, *THE LIMITS OF PROFESSIONAL POWER* (1980) (study of the nature of physician power and how it affects societal dynamics).

laws and medical education requirements that created a self-perpetuating, state-sanctioned monopoly.⁴⁹ During the following quarter century, the medical profession harnessed the hospital through accreditation standards that ensured costless and unrestricted use of these capital-intensive facilities essential to modern practice.⁵⁰

In the mid-twentieth century, physician influence focused on mechanisms of payment. Of the variety of insurance structures that might have taken shape, the predominant model, indemnity, was one that neither intervened in doctors' relationships with patients and hospitals nor interfered with their style of practice.⁵¹ The Great Society programs of the 1960s reflect the continuing institutional accommodation of physician interests. Cowed by fears of physician and hospital boycotts, lawmakers encumbered Medicare and Medicaid with a number of structural elements patterned on the prevailing private insurance model. The dominating protectionist influence is codified in the program's first words, which guarantee freedom from "any supervision or control over the practice of medicine or the manner in which medical services are provided."⁵²

Physician dominance has also manifested itself through the defeat of public programs that threaten professional interests. The AMA has had astounding lobbying and boycotting successes against national health insurance, prepayment plans, and a number of other social welfare and private financing programs that threatened doctors' economic security and professional sovereignty.⁵³ In short, "[o]ur entire health

⁴⁹ See S. GROSS, *OF FOXES AND HEN HOUSES: LICENSING AND THE HEALTH PROFESSIONS* 55-59 (1984) (recounting the role of licensing in the formation of medicine as a "profession"); P. STARR, *supra* note 30, at 102-12, 123-27 (describing how licensing and education consolidated the professional authority of physicians).

⁵⁰ See *infra* text accompanying notes 372-76.

⁵¹ Physicians suppressed or captured within circles of professional influence other financing models that would have placed doctors in a more subordinate position, models such as direct benefit insurance epitomized by the modern HMO and service benefit insurance epitomized by Blue Cross/Blue Shield. See P. STARR, *supra* note 30, at 306-310.

⁵² 42 U.S.C. § 1395 (1982 & Supp. IV 1986). The details of Medicare administration were left to private organizations under the control of the profession and industry and Medicare used liberal methods of reimbursement that assured that treating the needy would cause little or no sacrifice. See P. STARR, *supra* note 30, at 375-76.

The American experience is not unique. In his classic study of world wide systems of physician remuneration, William Glaser found that "[m]ost payment systems in public care schemes are simply those inherited from prior practice, . . . more bureaucratized versions of the methods that were used and often even invented by the doctors under earlier private practice." W. GLASER, *PAYING THE DOCTOR* 136 (1970).

⁵³ See E. RAYACK, *PROFESSIONAL POWER AND AMERICAN MEDICINE: THE ECONOMICS OF THE AMERICAN MEDICAL ASSOCIATION* (1967); Havighurst, *Professional Restraints on Innovation in Health Care Financing*, 1978 DUKE L.J. 303, 307-13 (discussing boycotts and related restraints); Law & Ensminger, *Negotiating Physicians'*

care system is organized largely to carry out decisions made by highly autonomous and independent physicians."⁵⁴ This deeply embedded professional sovereignty makes it foolhardy to predict the collapse of physician dominance based on a few cracks on the surface.⁵⁵

D. *Organization and Scope of Analysis*

The central project of this article is to demonstrate that undergirding the "institutional reinforcement of professional authority" observed by medical sociologists⁵⁶ is a strong legal infrastructure.⁵⁷ Be-

Fees, 61 N.Y.U. L. REV. 1, 53 (1986) ("Organized medicine contributes enormous resources to the political campaigns . . . [and] is able to mobilize their thousands of members in every part of the country as lobbyists."); Comment, *The American Medical Association: Power, Purpose, and Politics in Organized Medicine*, 63 YALE L.J. 938, 938 (1954) (finding the AMA to be in "a position of undeniable authority and influence").

⁵⁴ INSTITUTE OF MEDICINE, *THE NEW HEALTH CARE FOR PROFIT* 5 (B. Grey ed. 1983) [hereinafter *THE NEW HEALTH CARE FOR PROFIT*].

⁵⁵ See Freidson, *The Reorganization of the Medical Profession*, 42 MED. CARE REV. 11, 23 (1985); see also E. FREIDSON, PROFESSIONAL POWERS 129 (1986) ("Virtually all those who write of the decline of the professions ignore the institutions that support the position of the professions in the political economy."); Weiner, Maxwell, Sapolsky, Dunn & Hsaio, *supra* note 32, at 465 ("DRG proponents believed DRGs offered administrators not only the reason, but also the management tools needed to gain control over resource use within hospitals. . . . The flaw in this approach is the assumption that a change in hospital reimbursement policy will force a change in the distribution of decision-making authority within hospitals. . . . The proponents, however, ignore the organizational realities."). Thus, for instance, although the AMA is prevented from asserting the *ethical* impropriety of fee splitting, corporate practice, or restricted choice of physicians, doctors are not prevented from invoking *legal* challenges to these same activities. See *American Medical Ass'n v. Federal Trade Comm'n*, 638 F.2d 443, 452 (2d Cir. 1980) (holding that AMA was enjoined from imposing *ethical* restraints on the contract practices of physicians), *aff'd per curiam*, 455 U.S. 676 (1982).

⁵⁶ P. STARR, *supra* note 30, at 19-21.

⁵⁷ See E. FREIDSON, *supra* note 55, at 92-133 (discussing judicial and institutional treatment of professionals versus non-professionals); Freidson, *supra* note 17, at 70-71.

The law reinforces physician autonomy in a number of ways other than those explored in this Article.

(1) The medical malpractice standard of care defers to professional rules of conduct. Physicians have "the privilege, which is usually emphatically denied to other groups, of setting their own legal standards of conduct merely by adopting their own practices." E. FREIDSON, *supra* note 55, at 105 (quoting W. PROSSER, *HANDBOOK OF THE LAW OF TORTS* 165 (4th ed. 1971)); see also Havighurst, *The Changing Locus of Decision Making in the Health Care Sector*, 11 J. HEALTH POL. POL'Y & L. 697, 707 (1986) ("[T]he effect of the [customary practice rule] has been to give the medical profession the power to prescribe . . . its own standards.")

(2) Physicians may refuse to treat any patient, even in emergency situations, and even when the individuals are former patients and are able to pay for the services. See *Hurley v. Eddingfield*, 156 Ind. 416, 59 N.E. 1058 (1901); *Childs v. Weis*, 440 S.W.2d 104 (Tex. Civ. App. 1969).

cause the law absorbs and reflects the values and relationships of traditional medicine, it has codified the ethic of professional dominance, effectively shielding physicians from the institutional influence contemplated by revolutionary changes in health care policy.

The existing legal literature on health care cost containment misses the mark because it takes this institutional control as a given. It addresses the ethical and malpractice implications of cost containment, asking whether reductions in the quality or quantity of care produced by the new reimbursement systems are consistent with and may be accommodated by the existing legal and ethical duties of physicians.⁵⁸ This body of scholarship is necessarily premised on the assumption that cost containment efforts will change physician behavior in a significant manner. The extent to which this assumption is true is a critical question of a priori importance that determines whether ethical and liability concerns will ever manifest themselves on a widespread basis.⁵⁹

Close assessment of the legal doctrines that inhibit institutional control is required to determine whether a strong degree of professional autonomy is necessary to ensure the quality of health care, or perhaps, by stressing quality to the exclusion of other important considerations

(3) Medicare's maintenance of the convention of separate billing reinforces the traditional division of hospitals into two lines of authority, which implicitly preserves institutional noninterference as a protected value. See Havighurst, *supra*, at 704.

(4) Professional corporation laws allow professionals to enjoy the tax advantages of corporate existence without any threat to the autonomy of their individual practices. See E. FREIDSON, *supra* note 55, at 125-28.

(5) Regulatory programs also defer to physicians. Certificate of need laws, for instance, expressly exempt expenditures for physician offices, even purchases of extraordinarily expensive equipment. See *Boulware v. State*, 737 P.2d 502 (Nev. 1987) (magnetic resonance imager); *Clifton Springs Sanitarium v. Axelrod*, 115 A.D.2d 949, 497 N.Y.S.2d 525 (1985) (CAT scanner).

⁵⁸ See Bovbjerg, *The Medical Malpractice Standard of Care: HMOs and Customary Practice*, 1975 DUKE L.J. 1375, 1375-1414; Capron, *supra* note 28, at 746-58; Furrow, *The Ethics of Cost-Containment: Bureaucratic Medicine and the Doctor as Patient-Advocate*, 3 NOTRE DAME J.L. ETHICS & PUB. POL'Y 187 (1988); Furrow, *Medical Malpractice and Cost Containment: Tightening the Screws*, 36 CASE W. RES. L. REV. 985, 1032 (1986); Kapp, *Legal and Ethical Implications of Health Care Reimbursement by Diagnosis Related Groups*, 12 L. MED. & HEALTH CARE 245, 252 (1984); Mariner, *Prospective Payment for Hospital Services: Social Responsibility and the Limits of Legal Standards*, 17 CUMB. L. REV. 379 (1987); Marsh, *Health Care Cost Containment and the Duty to Treat*, 6 J. LEGAL MED. 157, 190 (1985); Morreim, *Cost Containment and the Standard of Medical Care*, 75 CALIF. L. REV. 1719, 1757-63 (1987); Schuck, *Malpractice Liability and the Rationing of Care*, 59 TEX. L. REV. 1421, 1421 (1981); Note, *Rethinking Medical Malpractice Law in Light of Medicare Cost-Cutting*, 98 HARV. L. REV. 1004, 1004 (1985).

⁵⁹ See M. Hall, *The Malpractice Standard Under Health Care Cost Containment: A Reply to Professor Morreim* (unpublished manuscript).

such as costs, autonomy has been promoted in order to preserve economic privilege and professional ideals. Therefore, this Article evaluates the feasibility and legality of management techniques that have the potential for convincing physicians to withhold at least some care previously considered necessary. In so doing, the Article does not attempt to design the optimal system of cost containment; a complete, normative evaluation would be inconceivably extensive and theoretically impossible. It is only possible here to determine in general terms the proper locus and structure of decisionmaking within the existing prospective payment systems. Accepting the premise of contemporary reimbursement policy that some reduction in the quantity and quality of care is required, this Article explores how reductions might be accomplished, not how far they should go.

Hospitals, HMOs, and other health care institutions might respond to cost containment pressures by: (1) dictating the details of treatment, (2) motivating physicians with financial incentives to practice more conservatively, or (3) restructuring their relationship with the medical staff to subordinate physicians to institutional constraints. Directing treatment runs afoul of laws prohibiting various forms of interference with the practice of medicine.⁶⁰ Sharing the profits generated from treatment reductions violates a recent federal statute⁶¹ and may constitute prohibited fee splitting.⁶² Restructuring hospitals is inhibited by laws requiring an open, independent, and self-governing medical staff.⁶³ The task at hand is to evaluate these laws against the dual demands of sound medical practice and cost containment policy.

II. INTERFERENCE WITH THE PRACTICE OF MEDICINE

A. *Ordering Physician Behavior*

The most direct method for reducing health care costs is to issue specific treatment instructions or restrictions. Traditional medicine has employed treatment protocols to some extent, but their coverage has been sporadic and their use has been more as a cautionary device than as a mechanism for enforcing rigorous cost control.⁶⁴ Recently, how-

⁶⁰ See *infra* notes 71-170 and accompanying text.

⁶¹ See 42 U.S.C. § 1320a to 7a(b) (West Supp. 1988); *infra* notes 207-11 and accompanying text.

⁶² See *infra* notes 171-260 and accompanying text.

⁶³ See *infra* notes 263-380 and accompanying text.

⁶⁴ Examples include: (1) Hospital pharmacy "formularies" used to determine when and how long expensive antibiotics can be prescribed. See J. EISENBERG, *supra* note 33, at 129; Morreim, *supra* note 58, at 1728 n.42. (2) Establishing limits on the authority of junior physicians to order complex procedures or prescribe expensive

ever, treatment directives have taken on a controversial role. Health care institutions are now issuing "rigid protocols or standards of care" with increasing frequency, covering a broader range of activity,⁶⁵ often as binding directives.⁶⁶ In an unscientific AMA survey,⁶⁷ two-thirds of the responding doctors reported hospital attempts to decrease length of stay or the number of medical procedures and diagnostic tests prescribed.⁶⁸ New York City pediatric clinics have implemented a computerized treatment protocol system that establishes mandatory "uniform diagnosis and treatment procedures . . . for 85% of pediatric illnesses."⁶⁹ The Blue Cross/Blue Shield Association recently issued a lengthy set of guidelines for ordering the fifteen most common diagnostic procedures.⁷⁰

drugs. See J. EISENBERG, *supra* note 33, at 130; Berki, *Commentary: DRGs, Incentives, Hospitals, and Physicians*, HEALTH AFF., Winter 1985, at 70, 73; see also Morreim, *Commentary: Stratified Scarcity and Unfair Liability*, 36 CASE W. RES. L. REV. 1033, 1040 (1986) (some hospitals do the same for general practitioners). (3) Mandatory second opinion programs for elective surgeries used by numerous insurance companies and state Medicaid plans. See J. EISENBERG, *supra* note 33, at 131. (4) Occasionally conferring on ethics committees the power to overrule a physician's proposed course of action. See Merritt, *The Tort Liability of Hospital Ethics Committees*, 60 S. CAL. L. REV. 1239, 1249 (1987).

⁶⁵ Spivey, *The Relation Between Hospital Management and Medical Staff Under a Prospective-Payment System*, 310 NEW ENG. J. MED. 984, 984-86 (1984); see also Omenn & Conrad, *Implications of DRGs for Clinicians*, 311 NEW ENG. J. MED. 1314, 1316 (1984) (hospitals "expect to have increasingly strong bargaining power with physicians to promote more standardized treatment regimens that are congruent with [DRG-based] reimbursement incentives"). John Eisenberg describes one hospital's protocol for determining when it is necessary to use cross-matched blood, see J. EISENBERG, *supra* note 33, at 130, and two Boston hospitals reportedly have instructed their obstetrical staff to discharge women within two days after a normal delivery. See Stern & Epstein, *Institutional Responses to Prospective Payment Based on Diagnosis-Related Groups*, 312 NEW ENG. J. MED. 621, 623 (1985); see also Finn, Valenstein & Burke, *Alteration of Physicians' Orders by Nonphysicians*, 259 J. A.M.A. 2549, 2550 (1988) (support staff added or deleted tests from doctors' written laboratory orders for 39 percent of the patients studied). See generally Eisenberg & Williams, *supra* note 4, at 2195 ("[C]osts could be decreased by limiting the size of the medical care 'engine' . . .").

⁶⁶ The binding nature of these directives varies with the enforcement technique employed. Physicians might be barred entirely from using an institution's facilities for a disapproved procedure, or compliance with protocols might simply be a condition to receiving reimbursement for the treatment. Complexities in the analysis caused by these variations are explored *infra* at notes 113-51 and accompanying text.

⁶⁷ The data was developed from a survey of 1000 physicians with an unreported response rate. The sampling technique was not described in the article and the data probably reflect a reporting bias. See AM. MED. NEWS, Dec. 5, 1986, at 17.

⁶⁸ See *id.*

⁶⁹ N.Y. Times, Feb. 29, 1984, at B24, col. 1; see also Freidson, *supra* note 55, at 28 (finding at outpatient pediatric clinics in two New York City hospitals, computers monitor compliance with treatment procedures that have been specified for 85 percent of the patients' complaints).

⁷⁰ See N. Y. Times, April 2, 1987, at A12, col. 1. Although the Blues are not yet using these guidelines to deny reimbursement, other insurers are. See HOSPITALS, May

Administrative controls such as these strike directly at the profession's most sensitive nerve, the preservation of clinical autonomy.⁷¹ Bureaucratic control is the antithesis of the collegial values inherent in professionalism. Eliot Freidson, a pioneering medical sociologist, discovered in a study of an HMO that "any effort at arbitrary quota-setting was resisted almost automatically by virtually everyone because it constituted an attack on freedom of judgment and practice."⁷² Physicians are well-armed in this resistance. Overt control of physician behavior implicates one of two legal doctrines, depending on the source and form of control. If a health care institution run by lay investors, directors, or administrators attempts to impose control through administrative restrictions and treatment protocols, it risks engaging in the unlicensed practice of medicine.⁷³ If treatment is ordered instead by supervising physicians, or if control is imposed through financial influ-

5, 1988, at 24, 25.

Various administrative regulations present less obtrusive ways of implementing treatment controls. Hospitals are revising laboratory test ordering forms to reflect the proper indications, intervals, sequencing and duration for testing. See Wong & Lincoln, *Ready! Fire! . . . Aim! An Inquiry into Laboratory Test Ordering*, 250 J. A.M.A. 2510, 2512 (1983) (describing authors' success at changing ordering forms for thyroid function tests from a simple check-off list to a "problem-oriented format" that requires the ordering physician to be more discriminating about the particular test ordered). There are four different thyroid function tests, each with a different purpose. With the check-off list, 80 percent of physicians ordered the complete panel of thyroid tests, essentially out of force of habit. See *id.* at 2510-11. Rather than attempting to determine in advance precisely which test was needed, they investigated the tests' meaning only if one showed an abnormal result. The revised form decreased substantially the number of complete panels ordered. See *id.* at 2511.

Another innovative technique is limiting the total number of tests per day that a physician can order, leaving to the physicians' discretion how best to allocate the restricted testing opportunities. See Dixon & Laszlo, *Utilization of Clinical Chemistry Services by Medical House Staff*, 134 ARCHIVES OF INTERNAL MED. 1064, 1064-67 (1974).

⁷¹ See Mechanic, *Rationing of Medical Care and the Preservation of Clinical Judgment*, 11 J. FAM. PRAC. 431, 432 (1980) ("Explicit rationing is the mode of control most resented by working professionals since it intrudes on their practicing autonomy and discretion in a direct way."); Weiner, Maxwell, Sapolsky, Dunn & Hsiao, *supra* note 32, at 476 ("Directives from administrators about the core of clinical practice — the detailed treatment regimens for patients — would not be accepted by physicians.").

⁷² E. FREIDSON, *DOCTORING TOGETHER* 229 (1975). "Even unsolicited advice was resented" as an invasion of clinical autonomy. *Id.* at 118; see also Goss, *Influence and Authority Among Physicians in an Outpatient Clinic*, 26 AM. SOC. REV. 39, 48 (1961) ("Following administrative regulations was evidently not very important to physicians when the regulations conflicted with the professional task of taking care of patients Consequently they felt free to disregard administrative requests on occasions when such conflicts arose."); Scott, *Managing Professional Work: Three Models of Control for Health Organizations*, 17 HEALTH SERVICES RES. 213, 229 (1982) (arguing that physicians resist external control on principle, even if the particular standard is not objectionable).

⁷³ See *infra* notes 75-103 and accompanying text.

ence rather than command, the concept of tortious interference with the physician/patient relationship, although not yet explicitly recognized, may create liability.⁷⁴ Both of these doctrines are concerned ultimately with the extent to which the law will countenance interference with a physician's medical judgment, whether from a source external to or within the profession.

B. *Lay Treatment Directives and the Unlicensed Practice of Medicine*

Courts frequently state that "a licensed physician may not accept directions and instructions in diagnosing and treating ailments from a corporation or an individual who is not a licensed practitioner."⁷⁵ In the words of one commentator, "any administrator who routinely proposed to dictate such daily details as which patient should receive how many chest x-rays or laboratory studies, who needs invasive monitoring, or who can be safely discharged, would be practicing medicine in the physician's stead."⁷⁶

To some extent, legal antipathy to detailed treatment standards is warranted. Command and control techniques raise a host of troubling concerns. At the most extreme, American medicine might follow the reported experience in the Soviet Union, where "the bureaucratic management of medical services . . . permits [the regime] to control and manipulate the dispensation of medical and allied services in about the same manner it controls . . . the production of tractors or the construction of industrial plants."⁷⁷ Physician resistance to such coercive regula-

⁷⁴ See *infra* notes 126-51 and accompanying text.

⁷⁵ *Iterman v. Baker*, 214 Ind. 308, 316-17, 15 N.E.2d 365, 370 (1938); see also *Rosane v. Senger*, 112 Colo. 363, 366, 149 P.2d 372, 374 (1944) (noting that "a hospital . . . is powerless, under the law, to command or forbid any act by [doctors] in the practice of their profession"); *South Bend Osteopathic Hosp. v. Phillips*, 411 N.E.2d 387, 388 (Ind. App. 1980) ("[H]ospitals, as such, are not entitled to engage in the practice of medicine in the sense of prescribing a course of treatment or exercising discretionary medical judgment in the diagnosis and care of patients."); *Brown v. St. Vincent's Hosp.*, 222 A.D. 402, 404, 226 N.Y.S. 317, 321 (1928) (noting that "hospital corporation may not . . . interfere with the method of treatment"); Comment, *The Hospital-Physician Relationship: Hospital Responsibility for Malpractice of Physicians*, 50 WASH. L. REV. 385, 392 (1975) (most state medical practices acts would be violated by hospital administrators' attempts to exercise control over medical treatment).

⁷⁶ Morreim, *supra* note 64, at 1040; see also Morreim, *Clinicians or Committees—Who Should Cut Costs?*, 17 HASTINGS CENTER REP., April 1987, at 45 (hospital administrative committees establishing guidelines for treatment would be practicing medicine without a license).

⁷⁷ M. FIELD, DOCTOR AND PATIENT IN SOVIET RUSSIA 41 (1957). Soviet doctors' "work must be under the constant scrutiny of persons and organizations that may have but little comprehension or sympathy for the intricacies, subtleties, uncertainties

tion might result in deceptive and potentially harmful behavior such as manipulating diagnoses or ordering unnecessary treatment.⁷⁸

However, the spectrum of possible administrative controls includes techniques less extreme than scrutinizing and countermanding each discrete treatment decision. A hospital might set general limits, subject to exception, on the length of stay, the number of diagnostic tests and procedures, or the quantity of medications for particular conditions. Less intrusively, a hospital may simply inform physicians about these suggested guidelines. In short, it is not enough to observe that medical licensure proscribes lay personnel from practicing medicine; it is necessary to determine precisely which actions fall within the scope of this proscription.

1. The Definition of Medical Practice

The starting point for this analysis is the physician licensing laws' all-encompassing definition of medical practice as diagnosing, treating, or prescribing for any physical or mental condition.⁷⁹ Case law interpreting these statutes for the most part addresses exotic peripheral ministrations that range from the sublime to the absurd.⁸⁰ While the terms

and unknowns that surround [medical] work. . . . Stated more simply, the doctor may be told, 'Illness interferes with the production of engines.' " *Id.* at 40-41.

⁷⁸ See *Mechanic*, *supra* note 71, at 432 ("Physicians and patients seek to manipulate and evade rules they view as irrational, and often such adaptive responses bring about subterfuge, perverse outcomes, and inequities in distribution.").

⁷⁹ See, e.g., CAL. BUS. & PROF. CODE § 2052 (West Supp. 1987).

⁸⁰ Courts have said that the following may constitute medical practice: magnetism, mental suggestion, faith healing, color wave therapy, nutritional advice, reflexology, massage, hypnotism. See *United States v. Article Consisting of Two Devices*, 255 F. Supp. 374, 381-82 (W.D. Ark. 1966) (color wave therapy), *rev'd on other grounds sub nom.* *United States v. Shock*, 379 F.2d 29 (8th Cir. 1967); *Parks v. State*, 159 Ind. 211, 64 N.E. 862 (1902) (magnetism); *State ex rel. Medical Licensing Bd. v. Brady*, 492 N.E.2d 34, 37 (Ind. App. 1986) (tattooing); *Pinkus v. MacMahon*, 129 N.J.L. 367, 368, 29 A.2d 885, 886 (1943) (nutritional advice); *People v. Molford*, 140 A.D. 716, 171, 125 N.Y.S. 680, 681 (1910) (suggestive therapy), *aff'd*, 202 N.Y. 624, 96 N.E. 1125 (1911); *Evans v. Hoyme*, 78 S.D. 509, 514, 105 N.W.2d 71, 75 (1960) (reflexology); *State v. Pratt*, 92 Wash. 200, 200, 158 P. 981, 981 (1916) (suggestive therapy, prayer, and faith healing); Annotation, *Acupuncture as Illegal Practice of Medicine*, 72 A.L.R.3d 1257, 1257-63 (1976); Annotation, *Hypnotism as Illegal Practice of Medicine*, 85 A.L.R.2d 1128, 1128-30 (1962); Annotation, *Regulation of Masseurs*, 17 A.L.R.2d 1183, 1184-91 (1951).

These examples indicate how far courts are willing to go in supporting the medical profession's desire to protect its domain. Equally revealing are examples of unlicensed practice challenges that have failed. Showing how far the profession is willing to go in attacking peripheral activities under the unauthorized practice prohibition demonstrates the breadth of the prohibition's potential chilling effect. See *Hicks v. Arkansas State Medical Bd.*, 260 Ark. 31, 31-32, 537 S.W.2d 794, 794-95 (1976) (ear piercing challenged as unauthorized surgery); Annotation, *Validity, Construction, and Effect of Statute or Ordinance Regulating Beauty Shops, or Beauty Culture Schools*, 56

"diagnose, treat, or prescribe" broadly delimit the activity that constitutes medical practice, the more relevant question is what *degree of involvement* in such activity violates the medical practice act. Merely suggesting a course of treatment may fall within the literal concepts of diagnosis and prescription, but the statute may contemplate something more than kibitzing in order to trigger its criminal sanctions. It is helpful, then, to distinguish two degrees of involvement: (1) general directives subject to exception in particular cases, and (2) detailed, binding directives specific to each patient.

2. General, Nonbinding Directives

Many institutional medical directives are largely advisory. For instance, some hospitals prohibit routine chest X-rays at admission unless the physician finds that her patient presents a history or indication of respiratory disease.⁸¹ Such general directives, subject to exception in particular cases, should not be considered the practice of medicine. They pose no risk of either delivering incompetent medical care or deceiving the patient about the practitioner's qualifications, the two harms protected by medical licensure.⁸² A medical institution might devise various ways to influence a physician's judgment, including lay advice, but these controls do not threaten substandard care or mislead the patient as to who ultimately determines treatment if the decision to comply with or deviate from guidelines ultimately lies with the patient's attending physician. Even the profession's own ethical norms do not proscribe supervision so long as it takes the form of advice.⁸³ Although general medical directives go beyond mere advice by setting a mandatory baseline from which doctors must affirmatively justify deviation, setting broad parameters within which physicians must act does little to confine their essential clinical prerogative. The physician's

A.L.R.2d 879, 904 (1957) (beauticians challenged as practicing medicine without authorization).

⁸¹ See Armistead & Hofmann, *Involving the Physician in Cost Containment*, HOSP. FIN. MGMT., Jan. 1981, at 52, 54; Eisenberg & Williams, *supra* note 4, at 2198.

⁸² See *Batty v. Arizona State Dental Bd.*, 57 Ariz. 239, 254, 112 P.2d 870, 877 (1941) (describing the purpose of medical licensure as protecting the public from those who are not properly qualified); *State ex rel. Lacerenza v. Osborn*, 133 Conn. 530, 532, 52 A.2d 747, 749 (1947) (arguing that statutes designed to safeguard the public); *Bartron v. Codrington County*, 68 S.D. 309, 315, 2 N.W.2d 337, 342 (1942) (noting that purpose to establish a high standard of competence, and to protect patients from the ministrations of a "quack"); *Kelly v. Carroll*, 36 Wash. 2d 482, 492, 219 P.2d 79, 85 (noting that "purpose is to eliminate incompetent persons from holding themselves out to treat the public"), *cert. denied*, 340 U.S. 892 (1950).

⁸³ See Goss, *supra* note 72, at 49.

ultimate authority supersedes the institution's influence so long as a substantial core of professional discretion remains.⁸⁴

A conceptual analysis produces the same result as the foregoing policy analysis. Medical practice requires a specific relationship between physician and patient; it is not performed in the abstract. The terms "diagnose, treat, or prescribe" each contemplate concrete actions with tangible effects on the patient. Advising a physician lacks this immediacy and finality because the attending physician retains responsibility for the final treatment decision. Therefore, general, nonbinding advice to physicians cannot form the basis for an unlicensed practice claim, even though a lay person may be making a medical judgment.

Unfortunately, there is no directly relevant case law against which to test this analysis.⁸⁵ An encouraging analogous line of authority, though, is the series of cases upholding the right of nonlawyers to author legal books, forms, and kits. Discussion of general legal doctrine in the abstract fails to result in the formation of an attorney-client relationship because it is not directed toward particular individuals with concrete legal problems. Consequently, such advice falls outside the proscription of the unlicensed practice of law.⁸⁶ If legal advice that is not directed to a specific individual falls outside the definition of legal practice, the same should be true for medical treatment protocols. Legal

⁸⁴ See generally Blois, *Clinical Judgment and Computers*, 303 NEW ENG. J. MED. 192, 192-96 (1980) (analyzing the unquantifiable aspects of clinical judgment that prevent establishing precise standards for medical diagnosis).

⁸⁵ In *State v. Abortion Information Agency*, 37 A.D.2d 142, 330 N.Y.S.2d 927 (1971), *aff'd*, 30 N.Y.2d 779, 285 N.E.2d 317, 334 N.Y.S.2d 174 (1972), the court enjoined the operation of a lay-owned abortion clinic because, among other reasons, the clinic employees "engage[d] in diagnosing a human or physical condition" by "inform[ing] the prospective patient as to the type of operation for which [she] qualified." *Id.* at 145, 330 N.Y.S.2d at 929. Under the court's analysis, merely giving advice regarding a course of treatment qualifies as practicing medicine. However, a critical element distinguishes this case so as to prevent its application here: the advice was rendered to patients, not physicians.

⁸⁶ The leading decision is *New York County Lawyers Ass'n v. Dacey*, 28 A.D.2d 161, 173-74, 283 N.Y.S.2d 984, 997-999 (Stevens, J. dissenting), *adopted at* 21 N.Y.2d 694, 287 N.Y.S.2d 422, 234 N.E.2d 459 (1967):

It cannot be claimed that the publication of a legal text which purports to say what the law is amounts to legal practice. . . .

. . . There is no personal contract or relationship with a particular individual. . . . This is the essential of legal practice—the representation and the advising of a particular person in a particular situation.

. . . .

At most the book assumes to offer general advice on common problems, and does not purport to give personal advice on a specific problem peculiar to a designated or readily identified person.

Id.; See also C. WOLFRAM, *MODERN LEGAL ETHICS* 838-40 (1986); Annotation, *Sale of Books or Forms to Enable Layman to Achieve Legal Results Without Assistance of Attorney as Unauthorized Practice of Law*, 71 A.L.R.3d 1000, 1000-1113 (1976).

advice, like medical diagnosis or prescription, is an activity at the core of professional practice. Purely advisory guidelines directed to physicians, therefore, certainly should pass muster. Even if institutional treatment directives pass through to patients by circumscribing to some extent the range of physicians' discretion, they are valid under the legal text precedent so long as they are not specific to the circumstances of individual patients.

This reasoning allows medical institutions considerable room for designing programs to constrain physicians' treatment decisions. If a hospital or HMO promulgates general regulations based on scientific studies or clinical research findings, requiring physicians to take account of the regulations does not constitute the practice of medicine. The institution has "no personal contract or relationship with a particular individual."⁸⁷

There are, however, two defects in this analysis. First, the publication of legal texts triggers greater first amendment protections than private directives within a medical institution. This constitutional weight may tip the scales in favor of protecting lay activity only when publication is involved. Second, there is some doubt whether the courts have followed the legal text precedent in the medical context.⁸⁸ Ultimately, then, we are left with no meaningful guidance on the medical practice act's application to general institutional guidelines. This indeterminacy is unfortunate. Cost containment is doomed if these criminal provisions forestall even recommending a cost effective course of treatment. While such advice may have little actual impact on realigning physicians' be-

⁸⁷ *Dacey*, 28 A.D.2d at 174, 283 N.Y.S.2d at 998.

⁸⁸ The closest case is *Kelley v. Texas State Bd. of Medical Examiners*, 467 S.W.2d 539 (Tex. Civ. App. 1971) (writ ref. n.r.e.), *cert denied*, 405 U.S. 1073 (1972), which enjoined a nonphysician's publication of *One Answer to Cancer*. The court held that this book, which advocated the correction of pancreatic enzyme deficiency as a cure for cancer, "is a diagnosis, treatment, and offer of treatment and therefore constitutes the practice of medicine." *Id.* at 544-45. In another case, a Delaware court ruled that a nonphysician's public lectures on the therapeutic use of color waves "would constitute a violation [of the medical practice act] . . . though no particular person was singled out and given that recommendation or advice." *State v. Ghadiali*, 36 Del. 308, 313, 175 A. 315, 318 (Gen. Sess. 1933), *cert. dismissed*, 292 U.S. 653 (1934).

These two decisions may not be as preclusive as they first appear. The Delaware decision merely reported the jury instructions, unaccompanied by any critical analysis. *Kelley* involved much more than the publication of a medical text. The author had suggested to the public that he was a physician, which is an independent violation of the medical practice act, and the book was being "used as an illegal tool to aid and abet the unlawful practice of medicine in which actual doctor-patient relationships [were] being formed." *Kelley*, 467 S.W.2d at 545; cf. *KFKB Broadcasting Ass'n v. Federal Radio Comm'n*, 47 F.2d 670, 672 (D.C. Cir. 1931) (contrary to the public interest for a physician to offer medical advice over the airwaves when the physician responded to letters describing particular cases and usually recommended one of his own products as a cure).

havior, it is a necessary first step toward effective cost containment.

3. Detailed, Binding Directives

It remains to be seen whether a lay administrator might go further and issue particularized and binding treatment directives. Such directives are inconsistent with the purposes of medical licensure. By removing final treatment authority from the physician, these directives entrust high-risk judgment to untrained personnel. Of greater concern is the patient's lack of notice of this behind-the-scenes puppeteering. Misleading patients as to the true decisionmaker's qualifications strikes at the core of medical licensure's purpose.⁸⁹ Approached conceptually, the binding nature of administrative orders in effect places the administrator in a direct treatment relationship with a particular individual. The attending physician's authority does not break the chain of command leading to the patient, as with non-binding directives.

Still, a lack of direct precedent⁹⁰ forces us to consult cases from another context for confirmation of this analysis. Hospital malpractice liability cases have had occasion to grapple with the extent of an institution's control over medical decisionmaking. Early cases held that hospitals were only responsible for accidents caused by administrative, not medical, actions. This limitation was premised on the reasoning that "a licensed physician may not accept directions and instructions in diagnosing and treating ailments from . . . an individual who is not a licensed practitioner."⁹¹

Modern cases reject this older law. They recognize direct corporate responsibility for the quality of medical treatment within hospi-

⁸⁹ See *supra* note 82 and accompanying text.

⁹⁰ *Strachan v. John F. Kennedy Memorial Hosp.*, 209 N.J. Super. 300, 507 A.2d 718 (App. Div. 1986) provided strong support for this analysis. There, the intermediate appellate court relied on the medical practice act in rejecting the contention that a hospital was liable for the emotional distress caused by a delay in declaring the death of the plaintiffs' brain-dead son and turning off life support: "The hospital administrator is not a physician. He is a business person. A hospital administrator has no right to tell a physician how to practice medicine. . . . The law does not impose upon a hospital administrator a duty to establish a procedure to tell physicians how to practice medicine." *Id.* at 317, 507 A.2d at 726-27. The New Jersey Supreme Court did not comment on the appellate court's logic when it reversed on other grounds, finding instead that the patient's physician had declared brain death several days before life support was removed and the delay was caused by the hospital administrator's interference. *Strachan*, 109 N.J. 523, 538 A.2d 346 (1988).

⁹¹ *Iterman v. Baker*, 214 Ind. 308, 316-17, 15 N.E.2d 365, 370 (1938). This case was superseded by statute. See *Sloan v. Metropolitan Health Council of Indianapolis, Inc.*, 516 N.E.2d 1104-07 (Ind. App. 1987) (holding that the doctrine of respondeat superior is applicable in the context of medical malpractice).

tals.⁹² Perhaps, then, the limitation on hospital control has been overthrown by a new regime. Prominent scholars contend that coupled with a hospital's new obligation for medical outcomes is a new authority to supervise and control the quality of medical treatment.⁹³ Likewise, in this newly emerging era of institutional responsibility for cost containment, the medical institution might contend that it should have new powers to limit the excesses of medical practice, even at the expense of invading the domain of medical judgment.

The two seminal cases that expanded hospital liability seem, on first reading, to support the argument that hospitals are now free to impose stringent controls on doctors. Language in both decisions rejects the notion that hospitals do not practice medicine. According to *Bing v. Thunig*, the leading case holding hospitals vicariously liable for the negligence of medical employees, "[t]he conception that the hospital does not undertake to treat the patient . . . no longer reflects the fact."⁹⁴ However, to the extent that this language suggests direct institutional authority over treatment decisions, it is misleading. The previous theoretical difficulty with extending vicarious liability to professional employees was that respondeat superior is premised on the ability to control the actions of employees whereas hospitals are prohibited by law from exercising such control over medical professionals.⁹⁵ The *Bing* court's resolution of this conflict was not to recognize the right of control; instead it reasoned that the lack of control is irrelevant.⁹⁶ By imposing vicarious liability despite the lack of control, *Bing* is more correctly viewed as reaffirming the limits of institutional authority.

*Darling v. Charleston Community Memorial Hospital*⁹⁷ has

⁹² See *Fridena v. Evans*, 127 Ariz. 516, 622 P.2d 463 (1980); *Tucson Medical Center, Inc. v. Misevch*, 113 Ariz. 34, 545 P.2d 958 (1976); *Darling v. Charleston Community Memorial Hosp.*, 33 Ill. 2d 326, 211 N.E.2d 253 (1965), *cert. denied*, 383 U.S. 946 (1966); *Bost v. Riley*, 44 N.C. App. 638, 262 S.E.2d 391, *cert. denied*, 300 N.C. 194, 269 S.E.2d 621 (1980).

⁹³ See Southwick, *The Hospital as an Institution—Expanding Responsibilities Change its Relationship with the Staff Physician*, 9 CAL. W.L. REV. 429, 437 (1973). Indeed, it has been imaginatively suggested that hospital administrators willingly accepted the new liability in order to gain the power of increased control. See Havighurst, *Doctors and Hospitals: An Antitrust Perspective on Traditional Relationships*, 1984 DUKE L.J. 1071, 1079.

⁹⁴ 2 N.Y.2d 656, 666, 143 N.E.2d 3, 8 (1957).

⁹⁵ Comment, *supra* note 75, at 392.

⁹⁶ See 2 N.Y.2d at 666-67, 143 N.E.2d at 8; see also Southwick, *supra* note 93, at 465 ("In short, professional individuals are deemed to be employees even though the practice of their professional work is not in fact subject to detailed control by lay hospital administrators."). Liability is imposed despite the absence of control because the hospital appears to be responsible for the treatment rendered inside its walls and appears to be acting as more than a mere physician brokerage agency.

⁹⁷ 33 Ill. 2d 326, 211 N.E.2d 253 (1965), *cert. denied*, 383 U.S. 946 (1966).

greater potential for revolutionizing institutional authority. It has been credited with the next quantum leap in hospital liability—recognizing direct (as opposed to merely vicarious) corporate responsibility for the supervision of care rendered in the institution, even by independent physicians.⁹⁸ The court reached this result despite the hospital's objection that hospital control of physician behavior constitutes the unauthorized practice of medicine.⁹⁹ *Darling* is the most influential hospital law opinion of the last 50 years. Its rejection of the unauthorized practice argument surely opens the way for hospital control of physician behavior.

But how wide is the opening? *Darling* is a very cryptic decision whose full import is found only in its progeny. Subsequent decisions eliminate any implication that lay administrators may dictate medical practice. *Darling's* direct institutional responsibility for patient care encompasses only an obligation to exercise care in the selection of physicians and to take some corrective action when deficient practice is detected.¹⁰⁰ This is nothing more than what early decisions had long recognized, even those decisions that were most adamant about hospital immunity.¹⁰¹ Even this limited institutional oversight is not the exclusive purview of management but is heavily influenced by physician participation.¹⁰²

⁹⁸ Hardy, *When Doctrines Collide: Corporate Negligence and Respondeat Superior When Hospital Employees Fail to Speak Up*, 61 TUL. L. REV. 85, 92-93 (1986).

⁹⁹ The hospital contended that "only an individual properly educated and licensed, and not a corporation, may practice medicine. . . . Accordingly, a hospital is powerless under the law to forbid or command any act by a physician or surgeon in the practice of his profession." *Darling*, 211 N.E.2d at 256. The court rejected this argument, deciding that the hospital could be held liable because it "failed to review Dr. Alexander's work or require a consultation." *Id.* at 258.

¹⁰⁰ See Hardy, *supra* note 98, at 98 (*Darling* has been followed when hospitals have failed to screen physicians' credentials or terminate their staff privileges); Southwick, *Hospital Liability: Two Theories Have Been Merged*, 4 J. LEGAL MED. 1, 44 ("None of the case decisions since *Darling* has endeavored to imply a [direct supervisory] role for lay hospital administrators or trustees.").

¹⁰¹ See, e.g., *Schloendorff v. Society of New York Hosp.*, 211 N.Y. 125, 129, 105 N.E. 92, 93 (1917) (holding that a hospital is not liable even for the negligence of its employed nurses but may be held liable if due care not taken in selecting its physicians).

¹⁰² AMA & AHA, THE REPORT OF THE JOINT TASK FORCE ON HOSPITAL-MEDICAL STAFF RELATIONSHIPS 29-33 (1985) [hereinafter AMA/AHA JOINT TASK FORCE]. Indeed, in the view of many, the hospital has effectively delegated so much of the authority back to the medical staff that the institution retains essentially no control. See *Weiss v. York Hosp.*, 745 F.2d 786, 796 n.14, 817 (3d Cir. 1984) (The medical staff with the authority to evaluate applications for privileges on behalf of the hospital, effectively operating as an officer of the hospital.); Comment, *Reallocating Liability to Medical Staff Review Committee Members: A Response to the Hospital Corporate Liability Doctrine*, 10 AM. J.L. & MED. 115, 128 (1985) ("[W]hile the [hospital governing] board retains control over administrative and managerial supervision, it must

Rather than revolutionizing hospital authority over physicians, as is frequently contended,¹⁰³ *Darling* and its progeny are more accurately viewed as reflecting the law's intransigence to change. Despite the courts' overwhelming acceptance of the concept of direct institutional *responsibility* for patient care, they have resisted essentially any expansion of institutional *authority*.

Health care organizations thus enter the new era of institutional responsibility for cost containment with strictly limited authority to direct the details of treatment. Due to the explicit statutory restrictions of the broadly worded medical practice acts, any management technique that approaches binding instructions from lay administrators in particular cases will likely be found to constitute the unlicensed practice of medicine. Although nonbinding advice or general guidelines should be permissible so long as they preserve a core of professional discretion, even this is not free from doubt under the expansive interpretation given the sweeping medical practice prohibitions.

C. *Tortious Interference with the Physician/Patient Relationship*

Analysis of institutional control as the unauthorized practice of medicine is somewhat misdirected. That doctrine is concerned with the relationship between practitioners and patients; the focus of the present inquiry is the relationship between practitioners and institutions. Only when administrative directives are case-specific and binding do they transfer directly to the patient and thereby place the institution in the position of a practitioner. This, however, presupposes a somewhat improbable and unrealistic state of affairs. Treatment protocols are rarely developed or supervised by lay administrators and they are rarely binding in an absolute sense. More typically, institutions (1) place the control function with physicians rather than with lay administrators and (2) use treatment guidelines merely as conditions on voluntary financial benefits. The first of these approaches avoids the unlicensed aspect of binding treatment directives while the second potentially avoids the coercive aspect. Nevertheless, these two refinements raise new analytical and practical concerns that relate to interference with the practice of medicine. The independence of medical judgment that is at the heart of the unauthorized practice doctrine can be invaded in ways other than those prohibited by the medical practice act. Medical judgment can be

delegate clinical evaluation responsibilities to the medical staff. Since the board is composed primarily of lay members of the community, it lacks the capacity to police the clinical aspects of a physician's practice.").

¹⁰³ See *supra* text accompanying note 93.

invaded from inside as well as from outside the profession and by influence as well as by compulsion. A more flexible legal tool for addressing these larger interference concerns is the doctrine of tortious interference. Development of that doctrine will reveal that the law thoroughly protects the purity of medical decisionmaking. It potentially restricts any form of non-medical influence from interfering with the clinical autonomy of individual physicians.

1. The Limits of Unlicensed Practice

a. *Physician Control of Physicians: Group Versus Individual Autonomy*

Placing the control function in the hands of doctors by employing supervisory physicians to issue treatment directives is an attractive solution to the institution/physician conflict inherent in current cost containment programs. Several thoughtful commentators advocate widespread adoption of peer review techniques¹⁰⁴ and preliminary research findings support their optimism.¹⁰⁵ Physicians are more qualified than lay administrators to direct the performance of medical tasks. Additionally, their expertise commands more respect. Under the direction of the institution, physician managers can be expected to pursue efficiency objectives more rigorously than the independent, practicing medical staff. Thus, physician administrators are expected to play a rapidly growing role under prospective payment.¹⁰⁶

¹⁰⁴ See, e.g., Morreim, *The MD and the DRG*, 15 HASTINGS CENTER REP., June 1985, at 36-38 (advocating "collectively revising protocols"); Omenn & Conrad, *supra* note 65, at 1315 ("The medical staff as a group might devise a set of cost-related treatment standards, monitor their peers, and then identify and act on variances from those standards."); Young & Saltman, *Medical Practice, Case Mix & Cost Containment*, 247 J. A.M.A. 801, 804 (1982) (arguing that "each hospital's medical staff, as a group, would be responsible both for establishing a schedule of cost-related treatment standards for their institution, then for actively monitoring their peers to ensure a sufficient level of compliance").

¹⁰⁵ See Becker, Shortell & Neuhauser, *Management Practices and Hospital Length of Stay*, 17 INQUIRY 318, 329 (1980) (noting that efficiency is enhanced when administrators have increased knowledge of internal operations and when there is an increase in structure and rules guiding the behavior of individual physicians).

¹⁰⁶ See Sloan v. Metropolitan Health Council, 516 N.E.2d 1104, 1109 (Ind. App. 1987) (describing HMO in which "staff physicians were under the control of the medical director, a physician, who policed medical services and established policy. His judgment was final."). The experience in New Jersey, the first health care system to institute prospective payment under a DRG system, verifies the appeal of physician administrators. It has witnessed a "dramatic increase in the number of full-time, salaried medical directors and chiefs of service." Vladeck, *supra* note 32, at 585; see also M. ROEMER & J. FRIEDMAN, *supra* note 30, at 299 (the future prospects for physician managers are "bright"); Kindig & Lastiri, *Administrative Medicine: A New Medical Specialty?* HEALTH AFF., Winter 1986, at 146, 155 ("There is every indication that the

Physician control of physicians offers an escape from the unlicensed practice of medicine prohibition. The unlicensed practice doctrine is aimed at preserving professional sovereignty over practice at a group rather than an individual level. It is satisfied so long as freedom from lay interference is assured.¹⁰⁷ It does not address individual physicians' freedom from control within the profession. Thus, an institution that sets general efficiency policies and guidelines, leaving to physician managers the particular treatment directives, is not engaged in the practice of medicine. So long as the supervising physician's discretion is not controlled by the institution, no unlicensed person makes a medical decision.¹⁰⁸ The lack of controversy is demonstrated by the virtual silence of the case law and academic commentary on the question of physician control of physicians.

Nevertheless, this proposal remains troubling. Simply replacing the institution with its physician representative as the agent for imposing cost-sensitive treatment protocols does little to lessen interference with medical practice or to eliminate concern over medical judgment being influenced by non-medical factors. Medical decisions would still be made by someone other than the patient's physician, displacing the actual treating physician's judgment. The patient's nominal treating physician would be reduced to a conduit for treatment directives from the supervising physician and for clinical information from the patient. As a result, the supervising physician would be "practicing medicine in the [attending] physician's stead."¹⁰⁹

Medical peer review is premised on physician responsiveness to professional rather than lay supervision. However, physicians prize both their individual and their group autonomy.¹¹⁰ Eliot Freidson's pi-

number of physicians involved in administration will increase in the future."); Weiner, Maxwell, Sapolsky, Dunn & Hsiao, *supra* note 32, at 478 ("New Jersey hospitals increasingly found that it was useful to create or expand the position of chief of the medical staff to interpret their concerns about length of stay to attending physicians in a legitimate professional manner.").

¹⁰⁷ See *supra* notes 81-83 and accompanying text.

¹⁰⁸ Likewise, under the corporate practice of medicine doctrine, see *infra* notes 282-309 and accompanying text, although physicians are employed, they are not employed as treating physicians, only as administrators. This limited employment is in keeping with the traditional industry practice of hiring medical directors. The policies against corporate practice are not implicated because of the minimal intrusion in medical affairs. See *Sloan*, 516 N.E.2d at 1109 (respondeat superior liability is not avoided by corporate practice concerns at an HMO where the "employee-physician was supervised by a physician, not a layperson").

¹⁰⁹ Morreim, *supra* note 46, at 267. Among other issues that this displacement raises is whether the patient is aware of and has consented to the supervising physician's involvement. Full development of this informed consent question, however, is beyond the scope of the present analysis.

¹¹⁰ "Professional autonomy is based on the belief that the qualified practitioners

oneering work has documented the gripping control of the professional rules of etiquette that govern the medical collegium. The strongest of these rules is preservation of clinical autonomy, the freedom to follow individual judgment without constraint, short of "blatant or gross deficiencies."¹¹¹ Thus, the importance of individual autonomy to professional interests is equal to the sanctity of group autonomy.¹¹² If previous experience serves as a reliable guide, we can expect that the law will protect individual autonomy as well. Yet, to prevent control from within the profession, physicians will need to search for law other than that contained in medical practice acts.

b. *Institutional Inducement: Lay Influence Versus Command*

Medical institutions could also avoid unlicensed practice of law by exerting control through inducement rather than command. When insurance companies refuse to pay for medical treatment they consider unnecessary, we do not think of them as dictating to physicians how to practice medicine.¹¹³ These third-party payors are merely setting limits on what treatment they are willing to reimburse. Medical institutions might also structure utilization review programs to impose economic

are best able to determine how the function ought to be performed, and that each practitioner must be free to exercise his own judgment in the specific case." W. KORNHAUSER, *SCIENTISTS IN INDUSTRY* 1 (1962).

¹¹¹ E. FREIDSON, *supra* note 72, at 241.

¹¹² It might be expected that supervising physicians would also honor this highly prized clinical autonomy ethic. Two studies of physician groups revealed that, when physicians are given institutional authority over clinical decisions, they are not inclined to exercise this managerial prerogative as binding authority. Mary Goss found that physician supervisors

were not prepared to give anything resembling an order to another doctor concerning the care of that doctor's patient. . . .

Observation of interaction among doctors in the medical clinic . . . revealed no instance in which a supervising physician officially requested a physician on the staff to follow a particular course of action in the care he gave his patient.

Goss, *supra* note 72, at 46. According to Eliot Freidson, these organizations experienced the neutralization of formal authority. "[M]uch of the formal authority . . . was neutralized by the reluctance of its holders to employ it and . . . by the unwillingness of the working physicians to grant it legitimacy." E. FREIDSON, *supra* note 72, at 105. Even advice was "resented" as an unsolicited invasion of clinical autonomy. *See id.* at 118. However, these studies were conducted in an era that was not sensitive to the need for institutional oversight of costs. It is possible that physician administrators will be more responsive to institutional pressure in a cost-constrained environment where the organization's existence may be at stake.

¹¹³ *See, e.g.,* F.T.C. v. Indiana Fed'n of Dentists, 476 U.S. 447, 465 (1986) (upholding Commission's rejection of the argument that an insurance company's use of x-rays to judge the medical necessity for dental claims "would constitute unauthorized practice of dentistry by the insurance company and its employees").

sanctions for excessive treatment.¹¹⁴ If the only sanction for noncompliance with a lay treatment directive is withholding a voluntary economic benefit, it is difficult to find the compulsion necessary for unlicensed practice. Indeed, it is already common for HMOs to require their physicians to obtain prior approval for hospitalization, specialist referral, or expensive diagnostic procedures such as CAT scans.¹¹⁵ The primary sanction for noncompliance is the HMO's refusal to pay for unapproved treatment. This ultimately leaves to the physician's and patient's choice whether to accept the HMO'S judgment of medical necessity.¹¹⁶

Directly supporting this position are several federal decisions relating to Medicare and Medicaid that explicitly hold that it is permissible "to place appropriate limits on [reimbursement for] medical services 'based on such criteria as medical necessity.'"¹¹⁷ The leading discussion of this issue is found in *Association of American Physicians and Sur-*

¹¹⁴ The institution could withhold an efficiency bonus or, at the extreme, could terminate the physician's access to its facilities. Further analysis of the latter sanction is contained *infra* at notes 315-58 and accompanying text.

¹¹⁵ See, e.g., *Grant v. Travelers Ins. Co.*, 343 Pa. Super. 310, 312 n.2, 494 A.2d 862, 863 n.2 (1985).

¹¹⁶ Cf. *Wickline v. State*, 192 Cal. App. 3d 1630, 239 Cal. Rptr. 810 (1986) in which the court refused to accept a denial of reimbursement from California's Medicaid program (called "Medi-Cal") in defense of a physician's premature discharge of the plaintiff:

The decision to discharge is . . . the responsibility of the patient's own treating doctor.

. . . .
[T]he physician who complies without protest with the limitations imposed by a third party payor, when his medical judgment dictates otherwise, cannot avoid his ultimate responsibility for his patient's care. . . .

. . . .
[W]hile Medi-Cal played a part in the scenario before us in that it was the resource for the funds to pay for the treatment sought, . . . Medi-Cal did not override the medical judgment of Wickline's treating physicians at the time of her discharge.

Id. at 1645-46, 239 Cal. Rptr. at 819; see also *Blum v. Yaretsky*, 457 U.S. 991, 1009-10 (1982) (arguing that for purposes of constitutional analysis, Medicaid denial of reimbursement for unnecessary services does not make a state responsible for a physician's decision to discharge a patient).

¹¹⁷ *Medical Soc'y v. Toia*, 560 F.2d 535, 538-39 (2d Cir. 1977) (quoting 45 C.F.R. § 249.10(a)(5)(i)). The Supreme Court considered this issue in *Beal v. Doe*, 432 U.S. 438 (1977), with respect to a Pennsylvania Medicaid requirement that the patient receive two confirming opinions for funding of "medically necessary" abortions. The Court declined to reach the merits because the record was insufficient "to ascertain whether this requirement interferes with the attending physician's medical judgment in a manner not contemplated by the Congress." *Id.* at 448. See generally Gosfield, *Medical Necessity in Medicare and Medicaid: The Implications of Professional Standards Review Organizations*, 51 TEMPLE L.Q. 229 (1978); Note, *State Restrictions on Medicaid Coverage of Medically Necessary Services*, 78 COLUM. L. REV. 1491 (1978).

geons v. Weinberger,¹¹⁸ which considered the validity of Professional Standards Review Organizations ("PSROs") (now called "PROs," peer review organizations) under the Medicare program. The court held that these entities, which determine instances of unnecessary treatment, do "not bar physicians from practicing their profession."¹¹⁹ The court reasoned:

The [PSRO law] does not prohibit a physician from performing any surgical operations he deems necessary in the exercise of his professional skill and judgment. It merely provides that if a practitioner wishes to be compensated for his services by the federal government, he is required to comply with certain guidelines and procedures enumerated in the statute.

. . . .

. . . [E]ach individual physician and practitioner has the ability to choose whether or not to participate in the program. It is true that there will exist economic incentive or inducement to participate in the program. However, such inducement is not tantamount to coercion or duress.

. . . "[T]o hold that motive or temptation is equivalent to coercion is to plunge the law in endless difficulties."¹²⁰

¹¹⁸ 395 F. Supp. 125 (N.D. Ill. 1975), *aff'd sub nom.* Ass'n of Am. Physicians & Surgeons v. Mathews, 423 U.S. 975 (1975).

¹¹⁹ *Id.* at 132.

¹²⁰ *Id.* at 134. Similarly, in *Rush v. Parham*, 625 F.2d 1150 (5th Cir. 1980), the court held that a state's categorical exclusion of sex change operations from Medicaid coverage was not an illegal interference with the attending physician's professional judgment concerning appropriate treatment. Rather, it was a permissible exercise of the state's broad discretion to tailor the definition of "medically necessary" to fit the requirements of its Medicaid program. *Id.* at 1155-56; *see also* *Cowan v. Myers*, 187 Cal. App. 3d 968, 978, 232 Cal. Rptr. 299, 305 (1986) (state may properly decide what *services* are necessary, leaving physicians to determine what *treatment* is necessary).

Finally, a series of decisions under the Medicare provision prohibiting federal "supervision or control over the practice of medicine," 42 U.S.C. § 1395 (1982), is instructive. *See* *College of Am. Pathologists v. Heckler*, 734 F.2d 859, 868 (D.C. Cir. 1984) (limitation of pathologist reimbursement does not constitute unlawful interference); *Home Health Care, Inc. v. Heckler*, 717 F.2d 587, 590-91 (D.C. Cir. 1983) (policing reasonableness of costs does not constitute interference with practice of medicine); *American Medical Ass'n v. Mathews*, 429 F. Supp. 1179, 1201-03 (N.D. Ill. 1977) (restrictions on reimbursement for expensive drugs do not constitute "supervision and control").

However, these decisions are not directly applicable to state unauthorized practice law. The PSRO case was decided under a constitutional attack and therefore may be more permissive than state law. Similarly, the *Wickline* case addressed tort liability for treatment decisions and the *Rush* case was decided under an analysis of the Medicaid statute's requirements for covered services.

There are several unsettling aspects to this reasoning, however. First, it echoes theories rejected in constitutional due process jurisprudence over the past several decades.¹²¹ The essence of the argument is that an institution may condition voluntary economic benefits with requirements that, if imposed outright, would be illegal. To the contrary, however, are rejection of the right/privilege distinction in constitutional law¹²² and the prohibition of unconstitutional conditions.¹²³

Second, this reasoning, carried to its logical extreme, would appear to hold the same result even if the economic consequence of engaging in disapproved treatment were loss of employment or hospital staff privileges. Just as insurance companies and the government are free to determine what treatment they are willing to cover, hospitals would be free to determine what sorts of physicians they want on the medical staff. It is not considered to be a coercive restriction that Catholic hospitals and Christian Science institutions impose specific limitations on the way in which medicine is practiced in their facilities.¹²⁴ Financially troubled hospitals likewise could enforce even detailed, case-specific treatment restrictions on pain of the loss of the opportunity to practice. The degree of intrusion and the underlying rationale is of no consequence under this line of reasoning.

Although funding limitations and other economic sanctions do not absolutely preclude physicians from following their own judgment, severe sanctions may have the same practical effect. Except in semantical and social niceties, a command does not differ elementally from a request attached to a consequence. If the consequence is an opprobrious sanction, any distinction between choice and compulsion becomes a chimaera. Realistically, physicians cannot be expected to treat patients repeatedly without reimbursement, and if the sanction takes the effect of

¹²¹ See J. BLUM, P. GERTMAN, & J. RABINOW, *PSROs AND THE LAW* 105 (1977).

¹²² See *Goldberg v. Kelly*, 397 U.S. 254, 262 (1970) ("The constitutional challenge [to a termination of welfare benefits] cannot be answered by an argument that public assistance benefits are 'a privilege' and not a 'right.'") (quoting *Shapiro v. Thomson*, 394 U.S. 618, 627 n.6 (1969)); see also Van Alstyne, *The Demise of the Right-Privilege Distinction in Constitutional Law*, 81 HARV. L. REV. 1439, 1464 (1968) ("Any per se constitutional distinction [between right and privilege] . . . would . . . reflect neither logic nor experience in the law.").

¹²³ See *Frost & Frost Trucking Co. v. Railroad Comm'n*, 271 U.S. 583, 594 (1926) (The state "may not impose conditions which require the relinquishment of constitutional rights."); Note, *Unconstitutional Conditions*, 73 HARV. L. REV. 1595, 1596 (1960) (noting the development by courts and commentators of the unconstitutional conditions doctrine).

¹²⁴ See, e.g., *Watkins v. Mercy Medical Center*, 364 F. Supp. 799, 803 (D. Idaho 1973) ("The hospital can prohibit staff from performing sterilization procedures or abortions in the hospital"), *aff'd*, 520 F.2d 894 (9th Cir. 1975).

exclusion from the workplace or from an entire federal or state program, noncompliance with medical directives can threaten the physician's very livelihood.¹²⁵

Yet there is still no clean analytical line that separates excessive financial inducements from those that seem benign. As with physician control of physicians, the unlicensed practice law is not capable of addressing interference with practice concerns at the level of subtlety demanded by real world practices.

2. Shielding Physicians from Interference

a. *An Inchoate Principle*

Observing the inapplicability of the medical practice act is not to say that the law is unconcerned with lesser degrees of interference than overt control of medical treatment by lay administrators. From several sources in the law there is evident a nascent principle that potentially insulates individual clinical decisions from nonmedical interference of any source or magnitude. Expressed positively, courts have commented that "the ability of a physician to exercise his professional judgment in the diagnosis and care of his patients is well-established and should be protected against unreasonable interference."¹²⁶ Similarly, the Medi-

¹²⁵ Unease with these realities is reflected in the federal courts' inconsistency on the validity of Medicare utilization controls. The same volume that reports *Association of American Physicians & Surgeons* also contains a case decided by another judge on the same court that applies the opposite reasoning to a very similar utilization review process. See *American Medical Ass'n v. Weinberger*, 395 F. Supp. 515 (N.D. Ill. 1975). The court reasoned with respect to a prior approval requirement for reimbursement of hospital admissions that "the practical effect of the regulations is to deny admission, even if the terms of the regulations do not." *Id.* at 523; see also *infra* note 140 and accompanying text (discussing courts' treatment of mandatory consultation conditions on hospital staff privileges). Another area of analogous precedent worth mentioning is the restriction on the FDA's authority to "interfere with medical practice." One court has held that this restriction prevents the FDA from limiting the uses for which a physician can prescribe an approved drug. See *United States v. Evers*, 453 F. Supp. 1141, 1149 (M.D. Ala. 1978) ("There is no indication that an over-65 indigent recipient of Medicare or Medicaid, if not admitted under these programs, could otherwise pay for the hospitalization prescribed by the attending doctor The potential injury to the patient's health may be irreparable."), *aff'd*, 643 F.2d 1043 (5th Cir. 1981); see also *American Medical Ass'n*, 395 F. Supp. at 523 (same).

¹²⁶ *Radiology Professional Corp. v. Trinidad Area Health Ass'n, Inc.*, 195 Colo. 253, 257, 577 P.2d 748, 751 (1978); see also *Linder v. United States*, 268 U.S. 5, 18 (1925) ("[D]irect control of medical practice in the States is beyond the power of the Federal Government."); *Evers*, 453 F. Supp. at 1150 ("The courts have rather uniformly recognized the patients' rights to receive medical care in accordance with their licensed physician's best judgment and the physician's rights to administer it may be derived therefrom."); *People v. Privitera*, 141 Cal. Rptr. 764, 774 (Ct. App. 1977) ("To require the doctor to use only orthodox 'state sanctioned' methods of treatment . . . is to invite a repetition . . . of the Soviet experience with 'Lysenkoism.' . . . A free,

care statute explicitly preserves the independence of medical judgment from federal interference.¹²⁷ Expressed in the negative, courts have found that no unauthorized practice exists where there is no interference with the physician/patient relationship,¹²⁸ thus indicating that the sanctity of this relationship is at the heart of the medical practice act.

The structure of mandatory second surgical opinion programs, which have grown quite common during the last decade,¹²⁹ manifests this sensitivity to protecting physician autonomy from *intra-* as well as *inter-*professional interference. These programs require as a condition of reimbursement for certain "elective" surgeries that the patient obtain a second, confirmatory opinion of the need for surgery. If the second opinion is negative, however, the patient may seek a third opinion. Even if the third opinion is negative, the patient may still undergo the operation.¹³⁰ Partly out of concern for preserving the integrity of the primary physician/patient relationship,¹³¹ the insurance companies and

progressive society has an enormous stake in recognizing and protecting this right of the physician."), *cert. denied*, 444 U.S. 949 (1979); *State ex rel. Walker v. Bergman*, 12 Kan. App. 2d 695, 697, 705, 755 P.2d 557, 560 (1988) ("recogniz[ing] limitations on the [nursing home] facility's ability to supervise the physician-patient relationship" by excluding a doctor from the premises); Relman, *supra* note 21, at 109 ("The courts have often shown themselves willing to defend the rights of patients to receive, and doctors to prescribe whatever medical services might be of some help—without regard to cost.").

¹²⁷ See 42 U.S.C. § 1395 (1982) (prohibiting federal "supervision or control over the practice of medicine or the manner in which medical services are provided"); *id.* § 1395a (guaranteeing free choice of provider).

¹²⁸ General advice not based on the circumstances of a particular case is unlikely to be characterized as unauthorized practice because no physician/patient relationship exists. See *supra* text accompanying note 82-87.

The corporate practice of medicine doctrine discussed in Part IV has also been found inapplicable on similar grounds. See *Los Angeles County v. Ford*, 121 Cal. App. 2d 407, 414, 263 P.2d 638, 642 (1953) (holding that medical school's treatment of indigents does not constitute corporate practice because no relationship is formed between hospital and patient); *Rush v. City of St. Petersburg*, 205 So. 2d 11, 14-15 (Fla. 1967) (finding no corporate practice violation when "the relationship of patient and physician is maintained by the medical staff The crux of the matter then is whether the relationship . . . has been so destroyed as to allow the hospital to become the medical practitioner"); *Rush v. Akron Gen. Hosp.* 171 N.E.2d 378, 380 (Ohio Ct. App. 1957) (arguing that employment of hospital interns does not violate doctrine because "[i]nterns do not have patients of their own"); 1954-1955 Va. Op. Att'y Gen. 146, 148 (1955) (stating "the relationship of doctor and patient [does not] exist[] between the radiologist and the patient [when the attending physician orders the X-ray and diagnoses the patient's condition]. Therefore, . . . a hospital would not be practicing medicine if it employed a radiologist to operate its X-ray Department . . .").

¹²⁹ See *Unnecessary Surgery: Double Jeopardy For Older Americans: Hearing Before the Special Comm. on Aging*, 99th Cong., 1st Sess. 75 (1985) (noting institution of voluntary and mandatory second surgical opinion programs in New York, Michigan, Pennsylvania, New Jersey, and Massachusetts).

¹³⁰ See *id.* at 173, 298-300.

¹³¹ See Comment, *Controlling Health Care Costs Through Commercial Insur-*

Medicaid plans that have devised these programs refrain from making the nontreating physicians' opinions binding,¹³² even though the control function is exercised through physician oversight and the only sanction is denial of reimbursement.

This same concern also accounts for the historical reluctance of private insurance companies to base reimbursement denials on lack of medical necessity.¹³³ Judicial decisions have shown distinct hostility toward allowing insurance companies to "'second guess' the treating physician's good faith judgment."¹³⁴ One particularly strongly worded opinion required reimbursement for an obese patient who was hospitalized simply for observation during an intensive dieting regimen, declaring that "only the treating physician can determine what the appropriate treatment should be for any given condition."¹³⁵

It is not enough, though, to argue loosely that any interference

ance Companies, 1978 DUKE L.J. 728, 738 ("Any attempt by an insurer to . . . impose cost controls through second opinions is likely to be challenged" under "the general rule proscribing the practice of medicine in the corporate form.").

¹³² Thus, these programs are "mandatory" only in the sense that patients must obtain, not follow, the second opinion.

¹³³ See, e.g., Havighurst & King, *Liver Transplantation in Massachusetts: Public Policymaking as Morality Play*, 19 IND. L. REV. 955, 965-66 (1986) (arguing that the Massachusetts Blue Cross and Blue Shield plans were "wedded to a vision of themselves as mere financing intermediaries bound to give effect to any doctor's prescription"); Stuart & Stockton, *Control Over the Utilization of Medical Services*, 51 MILBANK MEM. FUND Q. 341, 342 (1973) (noting the reluctance of health insurers to question the appropriateness of care on an individual case basis).

¹³⁴ *Van Vector v. Blue Cross Ass'n*, 50 Ill. App. 3d 709, 715-716, 365 N.E.2d 638, 643 (1977) (holding that ambiguous insurance policy is to be construed in favor of the insured so that physician's judgment of medical necessity is honored); see also *Hughes v. Blue Cross*, 199 Cal. App. 3d 958, 245 Cal Rptr. 273 (1988) (sustaining \$850,000 verdict for bad faith denial of insurance claim).

¹³⁵ *Mount Sinai Hosp. v. Zorek*, 50 Misc. 2d 1037, 1041, 271 N.Y.S.2d 1012, 1016 (N.Y. Civ. Ct. 1966). The court continued: "Any other standard would involve intolerable second-guessing with every case calling for a crotchety Doctor Gillespie to peer over the shoulders of a supposedly unseasoned Doctor Kildare." *Id.*; see also *Shumake v. Travelers Ins. Co.*, 147 Mich. App. 600, 608-09, 383 N.W.2d 259, 263 (1985) (The terms "necessarily incurred" and "required" in an insurance contract are ambiguous, and a physician is generally better equipped than lawyers to determine what is medically necessary.); *Carrao v. Health Care Serv. Corp.*, 118 Ill. App. 3d 417, 425, 454 N.E.2d 781, 788 (1983) (arguing that "the insured is justified 'in relying on the good faith judgment of his treating physician as to the medical necessity of services prescribed'") (citing *Van Vector*, 50 Ill. App. 3d at 720-21, 365 N.E.2d at 645); *Weissman v. Blue Cross of W. New York, Inc.*, 116 Misc. 2d 1063, 1068, 457 N.Y.S.2d 392, 396 (Buffalo City Ct. 1982) (granting summary judgment for plaintiff's claim that it is unconscionable for Blue Cross to exercise sole judgment over medical necessity), *rev'd*, 126 Misc. 2d 341, 342, 482 N.Y.S.2d 659, 660 (Erie Co. Ct. 1984) (finding triable issues of fact); J. APPLEMAN & J. APPLEMAN, *INSURANCE LAW AND PRACTICE* § 705.35 (1981) (stating that "coverage will be found where the treating physician determined that such hospitalization was necessary"). But see *infra* note 151 (some courts have allowed insurers to determine medical necessity).

with the physician/patient relationship is illegal simply because scattered language evinces a concern for protecting the primary physician/patient relationship. It is necessary to frame this concern within a recognized legal doctrine.¹³⁶

b. *The Tortious Interference Doctrine*

A novel approach to these issues is to view them through the lens of tortious interference with advantageous relationships. This broadly articulated private law doctrine protects against "improper" interference with any type of existing or prospective contractual relationship.¹³⁷ The doctrine is fully capable of activating the law's inchoate protection of individual patient/physician relationships from interference because the tort applies to any source of interference, lay or professional, and its highly malleable character allows it to adjust to varying degrees of interference. If a physician's judgment is dictated by orders from fellow professionals or if economic sanctions tied to treatment regimens are too severe, "impropriety" is the only concept the court must invoke to strike the arrangement.¹³⁸ Thus, a hospital or HMO that restrained a physi-

¹³⁶ Some courts and attorneys attempt to analyze these issues in constitutional terms, drawing force from the abortion cases' protection under the privacy interest of the "woman's right to receive medical care in accordance with her . . . physician's best judgment." *Doe v. Bolton*, 410 U.S. 179, 197 (1973); see, e.g., J. BLUM, P. GERTMAN & J. RABINOW, *supra* note 121, at 102. However, stretching these controversial decisions beyond the abortion context to extend to *any* medical treatment opens a Pandora's box of unwieldy questions. A host of essential health care laws ranging from physician licensure to FDA regulation would, contrary to existing case law, be cast in constitutional doubt if subjected to the scrutiny that the Supreme Court has given abortion laws in the past decade. See *People v. Privitera*, 23 Cal. 3d 697, 702, 591 P.2d 919, 922, 153 Cal. Rptr. 431, 433 (1979) (holding that the "right" to obtain laetrile is not protected by the right to privacy embodied in either the Federal or California constitutions); *Bowland v. Municipal Court*, 18 Cal. 3d 479, 487, 556 P.2d 1081, 1084, 134 Cal. Rptr. 630, 633 (1976) (California statute regulating midwifery does not violate the prospective mother's right to privacy).

In any event, only governmental health care institutions would be subject to such constitutional scrutiny. Similarly, the Medicare noninterference provision, 42 U.S.C. § 1395 (1982), which applies only to actions by federal officers or agents, does not cover private initiatives in response to government reimbursement policy.

¹³⁷ W. PROSSER & W. KEETON, *THE LAW OF TORTS* § 129 (5th ed. 1984); *RESTATEMENT (SECOND) OF TORTS* §§ 766A, 766B (1979).

¹³⁸ An important limitation of the tort potentially restricts its application in this context. The tort is far more accommodating of interference with prospective relationships than with existing ones under the theory that healthy competition requires solicitation of clients so long as they are not induced to breach existing contractual obligations. *RESTATEMENT (SECOND) OF TORTS*, §§ 768, 771 & comments (1979). An extension of this reasoning is that it is permissible to solicit a competitor's existing habitual customers because the continuation of an at-will relationship is analytically no more subject to protection than the formation of a prospective relationship. See *id.* § 768 comment i.

Because physician/patient relationships, like other supplier/consumer relation-

cian's medical judgment in any manner not considered appropriate by the law could be subject to liability. Indeed, several courts have sustained tortious interference as a legitimate theory under which to challenge exclusions from a hospital medical staff.¹³⁹ Also, in non-tort contexts, courts have relied on interference principles to police the validity of medical staff regulations such as mandatory consultation.¹⁴⁰

ships, are terminable at will, *see* *Kelly v. St. Vincent Hosp.*, 102 N.M. 201, 207, 692 P.2d 1350, 1356 (Ct. App. 1984), it might be argued that medical institutions enjoy carte blanche permission to intervene in that relationship as required to pursue their legitimate economic interests under a constrained reimbursement system. However, courts have balked at applying ordinary business logic to the special nature of the patient/physician relationship, finding that it "is deserving of more attention from the law than a businessman's expectation of profit from a purely commercial transaction." *Hammonds v. Aetna Casualty & Sur. Co.*, 237 F. Supp. 96, 100-01 (N.D. Ohio 1965); *see also* Annotation, *Liability in Tort for Interference with Attorney-Client or Physician-Patient Relationship*, 26 A.L.R.3d 679, 683 (1969) (Third parties who interfere with the physician/patient relationship will be held liable under the general principles of the tort of interference.).

¹³⁹ The following decisions have allowed tortious interference claims to go to trial: *Qasem v. Kozarek*, 716 F.2d 1172, 1179 (7th Cir. 1983) (hospital peer review committee's refusal to allow plaintiff to perform surgery); *Posner v. Lankenau Hosp.*, 645 F. Supp. 1102, 1111-1115 (E.D. Pa. 1986) (physician denied reappointment to medical staff); *Robinson v. Magovern*, 521 F. Supp. 842, 848 (W.D. Pa. 1981) (surgeon denied staff privileges), *aff'd*, 688 F.2d 82 (3d Cir.), *cert. denied*, 459 U.S. 971 (1982); *Scheller v. American Medical Int'l*, 502 So. 2d 1268, 1271-72 (Fla. App. 1987) (pathologist alleging that hospital denied basic support services and billing information); *Cowan v. Gibson*, 392 S.W.2d 307, 310 (Mo. 1965) (physician denied reappointment to medical staff); *Raymond v. Cregar*, 38 N.J. 472, 482-83, 185 A.2d 856, 860-61 (1962) (physician alleging malice behind denial of his reappointment to medical staff); *Straube v. Larson*, 287 Or. 357, 359, 600 P.2d 371, 373 (1979) (suspension of hospital staff privileges).

Other decisions reject interference challenges, but only after finding a lack of evidence of any actual interference. *See, e.g., Lewin v. St. Joseph Hosp. Auth.*, 82 Cal. App. 3d 368, 392-94, 146 Cal. Rptr. 892, 907-08 (1978); *Blank v. Palo Alto-Stanford Hosp. Center*, 234 Cal. App. 2d 377, 391-92, 44 Cal. Rptr. 572, 580 (1965) (exclusion from hospital's diagnostic x-ray department); *Cobb County-Kennestone Hosp. Auth. v. Prince*, 242 Ga. 581, 249 S.E.2d 581, 585-88 (1978) (collecting and discussing cases); *Adler v. Montefiore Hosp. Ass'n*, 453 Pa. 60, 75, 311 A.2d 634, 642 (1973) (stating "the record fails to show any impairment of the physician-patient relationship").

Hammonds is a rare and successful case of a *patient* complaining of interference in the doctor/patient relationship. *See Hammonds*, 237 F. Supp. at 99; *see also* Smith, *Insurance Carrier Liability as a Result of Pre-Admission Screening and Hospital Stay Guidelines*, 12 OHIO N.U.L. REV. 189, 207 (1985) (analyzing decisions).

¹⁴⁰ *See, e.g., Findlay v. Board of Supervisors*, 72 Ariz. 58, 66, 230 P.2d 526, 531 (1951) (striking mandatory consultation requirement at public hospital); *Albert v. Board of Trustees*, 341 Mich. 344, 359-60, 67 N.W.2d 244, 251 (1954) (declaring void a public hospital's requirement that junior members perform certain major operations only in the presence of senior physicians and holding that the hospital lacks the authority to control treatment or operation on patients by a duly licensed practitioner). While more recent decisions have upheld the right of hospitals to require consultation, they have done so only after taking pains to observe that "the final decision with reference to the need, mode, method, and dosage [for treatment] is left to the patient's physician." *Benell v. City of Virginia*, 258 Minn 559, 570, 104 N.W.2d 633, 637 (1960); *see also Cobb County-Kennestone Hosp. Auth.*, 242 Ga. at 148, 249 S.E.2d at 587 (citing

The flexibility of this doctrine is also its weakness. While some courts require a clear showing of malicious intent to interfere,¹⁴¹ the more prevalent approach is to consider motive as only one factor in the balancing process that determines impropriety.¹⁴² Thus, even if a medical institution's policies are pursued without any desire to interfere with the patient/physician relationship, realization that interference is the likely effect may be sufficient to impose liability if the judge's or jury's personal economic philosophy and social sympathy are aligned against the institution.¹⁴³ Lessening the degree of interference also does not provide a safe harbor for hospitals because the degree of interference is just one of the factors that courts balance to determine impropriety.¹⁴⁴ The resulting uncertainty of what activities courts will view as improper creates an unacceptable degree of risk in a dynamic business environment buffeted by rapidly changing policies and economic forces.

Thus, legal recognition of individual physician autonomy as a protected interest and the reluctance to confine tortious interference to a

Benell with approval); Annotation, *Validity and Construction of Contract Between Hospital and Physician Providing for Exclusive Medical Services*, 74 A.L.R.3d 1268, 1277 (1976) (analyzing *Benell*).

¹⁴¹ See *Lawler v. Eugene Wuesthoff Memorial Hosp.*, 497 So. 2d 1261, 1263 (Fla. Dist. Ct. App. 1986) (stating "interference [must] be both direct and intentional"); *Cameron v. New Hanover Memorial Hosp.*, 58 N.C. App. 414, 439, 293 S.E.2d 901, 916 (1982) (stating "'sometimes it is said that bad motive is the gist of the action.' Prosser § 129. Thus, . . . plaintiffs must show that defendants 'acted with malice and for a reason not reasonably related to the protection of a legitimate business interest'") (quoting *Smith v. Ford Motor Co.*, 289 N.C. 71, 94, 221 S.E. 2d 282, 296 (1976)).

¹⁴² See *Lewin*, 82 Cal. App. 3d at 394, 146 Cal. Rptr. at 908 ("Whether there is justification [or privilege] is determined not by applying precise standards but by balancing, in the light of all the circumstances, the respective importance to society and the parties of protecting the activities interfered with on the one hand and permitting the interference on the other.") (quoting *Willis v. Santa Ana Community Hosp. Ass'n*, 58 Cal. 2d 806, 810, 376 P.2d 568 26, Cal. Rptr. 640 (1962), *overruled on other grounds*, *Cianci v. Superior Court*, 40 Cal. 3d 903, 924-25, 710 P.2d 375, 387, 221 Cal. Rptr. 575, 587 (1985)); see also RESTATEMENT (SECOND) OF TORTS § 767 (1971); *id.* § 766 comment S (1979) (stating "what is meant [by the malice requirement] is not malice in the sense of ill will but merely 'intentional interference without justification.' Malicious conduct may be an obvious type of this interference, but it is only one of several types").

¹⁴³ The Restatement observes that "[e]conomic pressure of various types is a common means of inducing persons not to deal with another. . . . [T]he pressure may consist of the refusal to admit [the plaintiff] to membership into a trade association or a professional organization, [such] as a medical or legal association." RESTATEMENT (SECOND) OF TORTS § 767 comment C at 31 (1979); see also *Lewin*, 82 Cal. App. 3d at 376-77, 146 Cal. Rptr. at 896-97 (doctor excluded from closed-staff hemodialysis unit); *Blank*, 234 Cal. App. 2d at 381-82, 44 Cal. Rptr. at 574-75 (radiologist excluded from x-ray unit).

¹⁴⁴ See *Lewin*, 82 Cal. App. 3d at 393, 146 Cal. Rptr. at 907-08; RESTATEMENT (SECOND) OF TORTS, § 767 (1979).

predictable mode of analysis have the potential of chilling the innovation of new strategies to foster cost conscious physician practices. The courts appear to be policing the reasonableness of internal hospital rules by weighing the competing interests of the physician and the hospital.¹⁴⁵ This balance has been set only for rules that address the quality of medical care.¹⁴⁶ There is substantial doubt that courts would give the same weight to rules that hospitals justify on the basis of cost.¹⁴⁷ Even if the ultimate balance of reasonableness tips in the hospital's favor, the mere expense and risk of litigation deters innovation.

Nevertheless, it is possible to identify several categories of cases where tortious interference challenges should be summarily dismissed. Retroactive utilization review should be beyond reproach because it imposes only a minimal degree of interference.¹⁴⁸ In the context of quality

¹⁴⁵ See, e.g., *Lewin*, 82 Cal.App. at 389-90, 146 Cal. Rptr. at 905; *Radiology Professional Corp. v. Trinidad Area Health Ass'n*, 195 Colo. 253, 258-59, 577 P.2d 748, 751 (1978) (balancing interests of physicians and hospital when hospital entered exclusive contract for radiology services); *Fahey v. Holy Family Hosp.*, 32 Ill. App. 3d 537, 546-47, 336 N.E.2d 309, 316 (1975) (weighing competing interests of physicians and hospital with regard to hospital policy of requiring physicians to consult with colleagues before performing major gynecological surgery).

¹⁴⁶ Since the mid-1960s, hospitals have been charged with the duty of maintaining ongoing supervision of the quality of physician performance. See *supra* text accompanying notes 97-101. Courts have also recognized that the rapid pace of technological development in medicine since the mid-century has placed new demands on medical institutions. Courts have thus allowed hospitals to restrict the range of procedures that physicians may perform and to limit certain technologically complex fields to selected specialists, rejecting the challenge that such arrangements restrict the range of professional judgment or dictate to whom generalists may refer their patients. See, e.g., *Radiology Professional Corp.*, 195 Colo. at 258, 577 P.2d at 751-52; *Cobb County-Kennestone Hosp. Auth.*, 242 Ga. at 150, 249 S.E.2d at 588; *Fahey*, 32 Ill. App. 3d at 545, 336 N.E.2d at 315; *Benell v. City of Virginia*, 258 Minn. 559, 565, 104 N.W.2d 633, 637 (1960); *Adler v. Montefiore Hosp. Ass'n*, 453 Pa. 60, 82, 311 A.2d 634, 642, 645 (1973).

¹⁴⁷ For instance, it was only after much thought and analysis that the court in *Cobb County-Kennestone Hosp. Auth.* upheld a hospital requirement that physicians use the in-house facilities for CAT scans rather than transporting patients outside to a scanner owned by the physicians. Were a hospital to condition staff privileges on when and how often a physician may use its CAT scanner, the result might differ because the "preeminent consideration in adoption of such a resolution" would no longer be "the health and safety of the patient." *Cobb County-Kennestone Hosp. Auth.*, 242 Ga. at 150, 249 S.E.2d at 588.

¹⁴⁸ Other easily sustained cases include those in which a supervising physician is also the patient's physician. There, no interference occurs because treatment decisions are ultimately in the hands of one of the attending physicians. If the analysis were otherwise, the operation of teaching hospitals would be impossible since their functioning depends on senior physician approval of training physician orders. See E. FREIDSON, *supra* note 48, at 155. Also, non-mandatory directives do not contravene interference principles because there is no displacement of the physician's ultimate authority. Common examples include prohibiting "standing orders" for diagnostic workups on admission but allowing such workups with the specific, signed order of the attending physician in a particular case, and requiring an explanation before the continuation of

control, the law has resolved the tensions between professional autonomy and institutional control by allowing hospitals to evaluate a physician's past treatment experience without requiring contemporaneous intervention in the practice details of individual cases.¹⁴⁹ The same compromise should apply in the context of cost control. Criticism of a physician's overutilization is no more interference with medical judgment than criticism of underutilization.¹⁵⁰ Even if retroactive review is particular to specific cases, as occurs when insurance companies or government programs refuse to pay based on the lack of medical necessity, the after-the-fact nature of the determination should preclude an interference challenge.¹⁵¹

D. *Interference Doctrine and Physician Autonomy*

1. The Law's Protection of Group and Individual Autonomy

The crux of our problem is this: In order for health care cost containment to succeed, we must abandon the established orthodoxy that shields the purity of medical decisionmaking from any outside influence, yet retain that degree of protection necessary to ensure sound medical judgment. The law has not yet struck the proper balance.

prophylactic antibiotic treatment for more than 24 hours.

¹⁴⁹ Thus, the hospital tissue committee might conclude that a surgeon's low percentage of diseased tissues removed indicates an excessive number of unnecessary operations.

¹⁵⁰ Active screening of medical decisions in particular cases before or during the process of treatment differs markedly from retroactive evaluation, in much the same way that prior restraints on speech differ from prosecutions for past speech-related offenses. A utilization review committee's finding that a physician is ordering too many x-rays, for example, is a finding in the abstract, and any interference in the treatment of a particular patient is speculative and attenuated. See Scott, *supra* note 72, at 220. Two contemporaneous Northern District of Illinois decisions that reached different outcomes on the validity of separate Medicare utilization review programs nicely illustrate this point. See *supra* text accompanying notes 118, 125. Weinberger, which invalidated a utilization review program, concerned a prior authorization requirement for the hospitalization of each patient. Mathews, which upheld PSRO review, concerned the setting of general treatment standards that applied only in the abstract.

¹⁵¹ Such review does not prohibit performance of the procedure; it only imposes a financial burden on the patient. While this is interference to some degree, it is essential to any effective oversight: the insurer's only alternative is to submit to the conflict of interest inherent in allowing the physician who is paid to be the sole judge of the necessity of the service. As one court recently explained in upholding medical necessity review, "it is unlikely that any insurer could permit the subscriber free selection of a physician if it were required to accept without question the physician's view of reasonable treatment and good medical practice." *Sarchett v. Blue Shield*, 43 Cal. 3d 1, 11, 729 P.2d 267, 274, 233 Cal. Rptr. 76, 83 (1987); see also *Lockshin v. Blue Cross*, 70 Ohio App. 2d 70, 72-73, 434 N.E.2d 754, 756 (1980) (arguing that "a function, basic to the insurer, is the right . . . to determine whether . . . [a] claim should be allowed or rejected'").

Medical practice acts properly limit the use of lay medical directives to achieve institutional influence through command from outside the profession. Medical institutions may avoid this limitation by imposing control from within the profession, but this too will cause massive professional resistance because physicians prize both their collegial and their clinical autonomy. While the law's treatment of more subtle forms of interference in the patient/physician relationship has not yet been formulated into doctrine, tortious interference is fully capable of protecting doctors from all forms of encroachment on medical judgment, whether from a lay or a peer source.

The law has always accommodated a degree of institutional oversight of medical practice. For example, hospitals may supervise physicians to promote the quality of health care¹⁵² and religious institutions may prohibit specific procedures to promote their beliefs.¹⁵³ The same accommodation is required in an era of cost containment and the tortious interference doctrine allows sufficient flexibility to accommodate the demands of this complex policy environment. The risk is still strong, however, that courts will apply the undefined tortious interference concept with an inflexibility that fails to recognize the need for some economic influence. Thus, the law fully embodies physicians' intensely libertarian professional ethic by protecting the prerogative of the individual doctor from potentially any nonmedical influence, including the costs of treatment.

2. Cookbook Medicine and the Art and Science of Health Care

Physician resistance to interference is warranted, to a degree. Most medical practice does not lend itself to lock-step directives from either lay or professional sources because of the intensely judgmental,¹⁵⁴ individualistic,¹⁵⁵ uncertain,¹⁵⁶ and humane¹⁵⁷ nature of health care. Thus,

¹⁵² See *supra* notes 97-99 and accompanying text.

¹⁵³ See *supra* note 124 and accompanying text.

¹⁵⁴ "[J]udgment as such cannot be objectified because it is at least in part a matter of opinion: it would not be wise to create formal codes or rules placing one opinion, theory, or school over another." E. FREIDSON, *supra* note 48, at 162.

¹⁵⁵

[M]edical practice is typically occupied with the problems of *individuals* rather than of aggregates or statistical units. . . . Thus, even when general scientific knowledge may be available, the mere fact of individual variability poses a constant problem for assessment that emphasizes the necessity for personal firsthand examination of every individual case and the difficulty of disposition on some formal, abstract scientific basis.

Id. at 164.

Harris argues that "top-down control" cannot "effectively modulate the individual, decentralized cost-benefit decision clinicians need to make." Harris, *supra* note 29, at

"efficiency protocols . . . can only be medically sound if they allow considerable room for clinical freedom."¹⁵⁸ As the argument is frequently put: "One cannot practice good medicine by committee or cookbook or computer. A person or group reviewing summaries of information cannot possibly appreciate all the clinical factors that make each situation different — and it is these judgments that make medicine such a complex, demanding profession."¹⁵⁹ The question for critical exami-

96-97. Havighurst makes the perceptive observation that the great range of possible exigencies for most medical services accounts for the absence of a regulatory or contractual approach in the law to governing medical decisions. "For most medical services, the range of possible exigencies is so great that no imaginable contract or regulation could explicitly state the physician's duty under all of them." Instead of an attempt to state a physician's duty explicitly, we rely on general notions of duty under tort law and a deference to professional custom. Havighurst, *Altering the Applicable Standard of Care*, 49 LAW & CONTEMP. PROBS. 265, 265 & n.1 (1986); see also Redisch, *Physician Involvement in Hospital Decision Making*, in HOSPITAL COST CONTAINMENT: SELECTED NOTES FOR FUTURE POLICY 217, 232 (M. Zubkoff, I. Raskin & R. Hanft eds. 1978) ("Medical cases are highly differentiated goods. No two patients are ever exactly the same . . ."); Stuart and Stockton, *supra* note 133, at 342 ("Because the best medical treatment is case-specific, it is difficult to set up hard and fast rules as to what constitutes 'overutilization' or 'unnecessary' treatment.").

¹⁵⁸ See *infra* text accompanying notes 177-82.

¹⁵⁷ "Administrative authority frequently becomes insensitive to the human dilemmas and variabilities so obvious at the clinical level, and administrative rules meant to cover a variety of situations frequently are insensitive to important contingencies." Mechanic, *supra* note 71, at 432; see also E. FREIDSON, *supra* note 72, at 252-54 (stressing the need to avoid the "human cost of turning the patient into an industrial product"); Fried, *Rights and Health Care — Beyond Equity and Efficiency*, 293 NEW ENG. J. MED. 241, 242 (1975) (warning that under an economic efficiency model of medicine, "the traditional conception of the physician as one owing an obligation of personal care to his individual patient would be substituted a conception of the physician . . . acting very much like a maintenance mechanic working on a stock of capital goods: a manual of procedures tells him what repairs to make, what repairs are too expensive to make, when it is more efficient to allow a machine to wear out rather than replace parts, and when machinery should be retired from service altogether as having reached the end of its useful life"); Morreim, *supra* note 46, at 267 ("[E]ven if we could formulate such directions . . . [m]edicine is not just a series of physical ailments and technical procedures, but a human relationship which must not be subordinated to a single-minded focus upon fiscal efficiency.").

¹⁵⁸ Morreim, *supra* note 46, at 273.

¹⁵⁹ Morreim, *supra* note 76, at 34.

The history of the progress of computer programs in grappling with clinical decisionmaking illustrates the strength of this limitation. Two decades of work on artificial intelligence in medical diagnosis have resulted in little success in developing a system capable of performing diagnostic tasks adequately. Existing programs "are virtually unable to cope with variations in the clinical picture" such as "the evolution of a disease over time . . . how one disease may influence the presentation of a second, or how the effects of previous treatment can alter the patient's illness." Schwartz, Patil & Szolovits, *Artificial Intelligence in Medicine: Where Do We Stand?*, 316 NEW ENG. J. MED. 685, 686 (1987), reprinted in 27 JURIMETRICS J. 362, 365 (1987). A number of theorists maintain that the attempt to replicate in computers "skills involving not only calculation but also judgment — is a dangerously misguided effort and ultimately doomed to failure." Dreyfus & Dreyfus, *Why Computers May Never Think Like Peo-*

nation, though, is exactly how much of medical practice is art rather than science?

We should be skeptical of the extent of judgmental latitude sought by doctors because much of the judgmental aura that surrounds medical practice is due to physicians' use of uncertainty to create domains of control and influence.¹⁶⁰ This uncertainty exists in part due to physician opposition to attempts at reaching a scientific consensus on questions of clinical practice. The profession's motives in suppressing the full play of scientific certainty are demonstrated by the AMA's active role in demolishing the National Center for Health Care Technology, an agency whose work was considered critical to achieving greater standardization in medicine. The AMA argued that "the center should not make general statements about appropriate medical care" because this was "trying to dictate the practice of medicine."¹⁶¹

Healthy skepticism is also warranted because the profession has taken widely inconsistent positions on the art/science characterization of medicine.¹⁶² Physicians trumpet the scientific basis of medicine when it suits their purpose. At the turn of the century, the medical profession relied on the scientific foundation of allopathic theory to establish exclusive authority over the domain of medical practice through licensing

ple, TECHNOLOGY REV., Jan. 1986, at 42, 44. At a minimum, "major intellectual and technical problems must be solved before we can produce truly reliable consulting programs." Schwartz, Patil & Szolovits, *supra*, at 687; see also Shortliffe, *Computer Programs to Support Clinical Decision Making*, 258 J. A.M.A. 61, 65 (arguing that "there are still major challenges to be overcome before integrated tools with broad clinical capabilities will be widely available"). Professional expertise is too dependent on intuitive thought processes that operate in a gestalt fashion. In short, medicine is more art than science. See Gatens-Robinson, *Clinical Judgment and the Rationality of the Human Sciences*, 11 J. MED. & PHIL. 167 (1986) (stating that medicine is a "human science" and interpretive rather than deductive in nature); Wartofsky, *Clinical Judgment, Expert Programs, and Cognitive Style: A Counter-Essay in the Logic of Diagnosis*, 11 J. MED. & PHIL. 81 (1986) (arguing that no computer program can simulate the essential elements of diagnostic procedure).

¹⁶⁰ See Saltman & Young, *supra* note 3, at 400 (arguing that "the central component of every group's strategy is an effort to maximize the sense of uncertainty among other groups").

¹⁶¹ See Sun, *Fishing for a Forum on Health Policy*, 219 SCIENCE 37, 37 (1983); see also Blumenthal, *Federal Policy Toward Health Care Technology: The Case of the National Center*, 61 MILBANK MEM. FUND Q. 584, 600-01 (1983) (describing the lobbying efforts of the AMA to persuade Congress to cut off funding for the center).

¹⁶² See Blois, *supra* note 84, at 192.

Whenever the topic of medical judgment is discussed . . . , some of the physicians will be apt to point out that medicine is as much art as science, and that rules cannot replace intuition and instinct. . . . When these same physicians are back with their medical students, they will probably be found describing the rules for doing this or that, while insisting that medicine is a science, not an art.

Id.

legislation.¹⁶³ In modern times, belief in a uniform standard of care provides the protection of professional custom as a defense to malpractice liability.¹⁶⁴

This skepticism calls for a more critical examination of the way in which the art/science dichotomy fits the law's preservation of physician autonomy. The medical profession depends on its scientific foundations to exclude alternative practitioners and thereby preserve group autonomy,¹⁶⁵ but if medicine were all science, doctors could not justify independence from fellow physicians. Consequently, the profession quickly shifts to clinical uncertainty to suppress even internal oversight. In this way, it plays both sides of the science/art fence in order to maintain complete freedom from control.

The flaw in this position is that clinical uncertainty does not preclude all forms of influence, only detailed directives. If a broad range of practice styles exist because we do not know the optimal level of care, then it is impossible to maintain that bad medicine results from influencing physicians to skew their treatment decisions toward a more conservative end of the grey zone of medical judgment. Bringing outside, non-medical influence to bear on clinical judgment is therefore consistent with both the art and the science of medicine: each is honored by leaving the final treatment decision with the physician.

3. The Prospects for Efficiency Protocols

Thus, while there may be an irreducible intuitive core to medical practice, the domain that belongs to art has been artificially inflated to preserve physician autonomy.¹⁶⁶ It is possible and desirable to bring greater definition and certainty to much of medical practice. Treatment protocols, whether written or computerized, serve some useful purpose

¹⁶³ See Havighurst, *supra* note 57, at 706. "In the public mind, medicine aspired to be, and therefore was treated as, an exact science. . . . Believing that there is a single right way . . . to diagnose and treat human disease, the public naturally accepted professional hegemony" *Id.*; see also P. STARR, *supra* note 30, at 144 (discussing the role of "lay deference [to] and institutionalized forms of dependence [on physicians' knowledge]" in establishing the monopoly of the medical profession); Branigan & Dayhoff, *Medical Informatics*, 7 J. LEG. MED. 1, 3-4 (1986) ("The development of 'scientific medicine' gave the medical profession a tremendous tool to exclude the lay public from medical decisionmaking.").

¹⁶⁴ See Havighurst, *supra* note 57, at 706.

¹⁶⁵ See E. FREIDSON, *supra* note 48, at 162-63.

¹⁶⁶ See E. FREIDSON, *supra* note 48, at 98 (arguing that as a defense to the evaluations of outsiders, physicians impute more uncertainty to their work than in fact exists); E. FREIDSON, *supra* note 30, at 164 (citing the tendency of physicians to emphasize the "primacy of firsthand clinical experience," thereby "exaggerating the acceptability of varying opinions").

simply as a checklist that forces physicians to think more carefully about their treatment decisions.¹⁶⁷ By setting a baseline to which physicians must refer in formulating their treatment plan, protocols may help revise and formalize the informal heuristics that are central to physicians' judgmental thought processes.¹⁶⁸ Critical to this role, though, is the limitation that treatment directives be nonbinding. Where written specifications exist in traditional medical practice settings, they consistently are formulated as guidelines or suggestions rather than as rules.¹⁶⁹ Even in today's environment where administrative rules are being considered more frequently and applied more broadly, the rules are not absolute.¹⁷⁰ In sum, while standardization of the science component of medical practice is unquestionably beneficial, the art of medical practice must be left unaffected.

Inevitably, then, treatment directives have only a limited potential for bringing medical decisionmaking within the arena of cost containment. Detailed standards are capable of covering only a very limited part of the medical treatment terrain, and it is impossible for both theoretical and practical reasons to impose on physicians a new treatment philosophy. They must be allowed to evolve their own practice styles. To precipitate and sustain this process, it is necessary to supplement general treatment guidelines with an intervention that maintains continuing influence on discrete treatment decisions, an intervention that alters more fundamentally the basic incentives that influence physician behavior.

¹⁶⁷ See Schwartz, Patil & Szlovits, *supra* note 159, at 687 (discussing the usefulness of computer-generated diagnostic hypotheses or plans for treatment by "provid[ing] a checklist that helps the user make certain that no . . . possibility has been overlooked").

¹⁶⁸ See *infra* notes 173-84 and accompanying text.

¹⁶⁹ See E. FREIDSON, *supra* note 55, at 228 ("[B]y the nature of the process by which they are formulated and agreed on, the vast majority of all professionally produced standards permit a significant amount of variation . . . on the part of the . . . professionals who are supposed to be governed by them."); D. YOUNG & R. SALTMAN, *THE HOSPITAL POWER EQUILIBRIUM* 168 (1985) ("Like all standards, the procedures prescribed [under our proposal] would not necessarily be rigidly adhered to in all circumstances. Instead, the standards would serve as a guide for each physician's patient-management decisions . . .").

¹⁷⁰ See Freidson, *supra* note 55, at 28 ("This opportunity [to deviate from treatment protocols] is provided to physicians in every review context with which I am now familiar. The rank and file practitioner thus has virtually statutory opportunity to use discretion in following standardized procedures and to deviate from them."); Marylander, *Management Professionals vs. Medical Professionals*, in 2 *CASE STUDIES IN HEALTH ADMINISTRATION: HOSPITAL ADMINISTRATOR-PHYSICIAN RELATIONSHIPS* 11, 16 (J. Hepner ed. 1980) ("Very few established administrative routines in hospitals cannot be abrogated or countermanded by a physician claiming medical emergency." (citation omitted)).

III. FINANCIAL INCENTIVES AND THE FEE SPLITTING PROHIBITIONS

A. *Motivating Physician Behavior*

The intervention with the best prospect for reconciling physician autonomy with cost control is structuring financial incentives to reward conservative treatment. We have learned that preserving physician autonomy, both on a collective and an individual level, is a social and a practical necessity for effective physician control.¹⁷¹ Only the exercise of professional judgment and discretion in each case will permit the individualization of patient care that is required to maintain humane service. What is needed, then, is some form of decentralized influence that preserves complete autonomy by internalizing cost consciousness at the bedside level. Health care can only be transformed by altering the process by which doctors make day-to-day treatment decisions. The need for intervention that fundamentally alters the basic incentives that influence physician behavior can be better understood after a closer examination of the nature of clinical judgment.

1. Financial Motivation and the Nature of Clinical Judgment

Some control strategies, such as physician education,¹⁷² mistakenly assume that doctors incorporate careful, systematic evaluations of alternative courses of treatment into their clinical decisionmaking in each case.¹⁷³ Instead, doctors, as do other professionals, operate from certain ground rules or "heuristics" as they are called. These decisionmaking shortcuts eliminate the need to reason from first principles and elemental facts in every case.

The best hard evidence of the nature of clinical judgment is provided by the several decades of work by Dartmouth epidemiologist John Wennberg. He has documented tremendous variations in the rate at which surgical procedures are performed among neighboring localities, despite nearly identical demographic and health profiles.¹⁷⁴ The

¹⁷¹ See *supra* notes 110-12 and accompanying text.

¹⁷² See, e.g., Wong & Lincoln, *supra* note 70, at 2511 (describing unsuccessful effort to lower the rate of laboratory test misuse through education).

¹⁷³ See *id.*

¹⁷⁴ See Wennberg, McPherson & Caper, *Will Payment Based on Diagnosis-Related Groups Control Hospital Costs?*, 311 NEW ENG. J. MED. 295, 296 (1984); see also Wennberg & Gittelsohn, *Variations in Medical Care Among Small Areas*, 246 SCI. AM. 120, 123 (1982) [hereinafter *Variations in Medical Care*] (noting that in the most populous areas of Maine, Rhode Island, and Vermont, the rates of tonsillectomy vary sixfold, the rates of hysterectomy and prostratotomy vary about fourfold); Wennberg & Gittelsohn, *Small Area Variations in Health Care Delivery*, 182 SCI-

reason for this extraordinary inconsistency in medical practice is that only a fraction of the vast range of medical procedures has been subjected to rigorous, controlled clinical trials.¹⁷⁵ "Medicine abounds with situations in which alternative clinical strategies are available with no scientific evidence indicating which is preferable."¹⁷⁶ Thus, it is seldom appreciated to what extent "[u]ncertainty pervades medical diagnosis and treatment."¹⁷⁷ "Medical knowledge is engulfed and infiltrated by uncertainty;"¹⁷⁸ it "creeps into medical practice through every pore."¹⁷⁹

Physicians find this degree of uncertainty extremely troubling.¹⁸⁰ Uncertainty is inconsistent with their scientific training and tends to undermine the profession's historical reliance on medicine's scientific foundations to justify its exclusive control over medical practice. "Professional certainty serves purposes of maintaining professional power and control over the medical decision-making process as well as of maintaining an aura of infallibility."¹⁸¹ Consequently, instead of acknowledging uncertainty, physicians assume a "mask of infallibility." "[T]he reality of medical uncertainty is generally brushed aside as doc-

ENCE 1102, 1104 (1973) (finding that Medicare reimbursement for diagnostic x-rays varied by 400 percent between service areas in the state of Vermont, and EKG reimbursement by 600 percent). Similar studies are collected and discussed in J. EISENBERG, *supra* note 33, at 6-8, 63; Komaroff, *The Doctor, The Hospital, and the Definition of Proper Medical Practice* (1981), in III PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, SECURING ACCESS TO HEALTH CARE 238-43 (1983) (appendix U); Paul-Shaheen, Clark & Williams, *Small Area Analysis: A Review and Analysis of the North American Literature*, 12 J. HEALTH POL. POL'Y & L. 741 (1987); Schroeder, *supra* note 4.

¹⁷⁵ See OFFICE OF TECHNOLOGY ASSESSMENT, *ASSESSING THE EFFICACY AND SAFETY OF MEDICAL TECHNOLOGIES* 7 (1978) ("It has been estimated that only 10 to 20 percent of all procedures currently used in medical practice have been shown to be efficacious by controlled trial.").

¹⁷⁶ Luft, *Economic Incentives and Constraints in Clinical Practice*, in APPLICATIONS OF SOCIAL SCIENCE TO CLINICAL MEDICINE AND HEALTH POLICY 500, 510 (L. Aiken & D. Mechanic eds. 1986).

¹⁷⁷ A. ENTHOVEN, *HEALTH PLAN* at xix (1980).

¹⁷⁸ J. KATZ, *THE SILENT WORLD OF DOCTOR AND PATIENT* 166 (1984).

¹⁷⁹ Eddy, *Variations in Physician Practice: The Role of Uncertainty*, HEALTH AFF., Summer 1984, at 74-75; see also Fortess & Kapp, *Medical Uncertainty, Diagnostic Testing, and Legal Liability*, 13 LAW MED. & HEALTH CARE 213 (1985); Fox, *The Evolution of Medical Uncertainty*, 58 MILBANK MEM. FUND Q. 1 (1980) (discussing the increase in the level of uncertainty brought about by modern scientific developments); Wennberg, Barnes & Zubkoff, *Professional Uncertainty and the Problem of Supplier-Induced Demand*, 16 SOC. SCI. MED. 811 (1982).

¹⁸⁰ See H. BURSZAJN, R. FEINBLOOM, R. HAMM & A. BRODSKY, *MEDICAL CHOICES, MEDICAL CHANCES* at xiv-xv (1981) ("[A] doctor may do anything to avoid being exposed as uncertain or in error -- in his or her own eyes, in the eyes of colleagues, in the eyes of patients and families who have been taught to expect 'scientific' accuracy from medicine, and perhaps even before a court of law.").

¹⁸¹ J. KATZ, *supra* note 178, at 198.

tors move from its theoretical contemplation to its clinical application."¹⁸² The clinical mentality is thus afflicted with a psychosis arising from the deep fear that the medical profession will lose control of health care practice if its scientific uncertainty is revealed.

Physicians attempt to cope with this schizophrenia by a sort of herd instinct: their clinical decisions are strongly influenced by a shared practice style.¹⁸³ To guide their daily treatment decisions, physicians rely heavily on a clinical instinct, an acting out of habit, that is learned as part of the professional "folklore" acquired during the professional socialization process.¹⁸⁴ Consciously or not, physicians act not from a scientific reexamination of first principles in each case but out of a shared practice style or philosophy grounded in soft reasoning processes such as intuition and judgment.

Consequently, the control strategy that will work best is to influence physicians to change their practice styles, to acquire a new treatment philosophy, through a motivational force that orients them toward a more conservative end of the acceptable range of variation in medical practice. We have witnessed this in Great Britain, where physicians are

¹⁸² *Id.* at 166; see also Luft, *supra* note 176, at 510 ("[I]ndividual physicians tend to prefer and to use one mode of treatment and do not behave as though there is a gray area characterized by uncertainty.").

¹⁸³ See Burum, *Medical Practice a la Mode: How Medical Fashions Determine Medical Care*, 317 NEW ENG. J. MED. 1220, 1222 (1987) (stating that "medical fashions have a powerful effect on how we treat . . . and . . . on the direction of medical science"); Wennberg, Barnes & Zubkoff, *supra* note 179, at 816-17; Wennberg & Gitelsohn, *Variations in Medical Care*, *supra* note 174, at 124 (describing as a "surgical signature" the common practices in different regions of Maine); Wennberg, *Dealing with Medical Practice Variations: A Proposal for Action*, HEALTH AFF., Summer 1984, at 6,7 (regional variations in medical care due to "practice style factor"); Wennberg, *Small Area Variations and the Practice Style Factor* (Feb. 15, 1988) (on file with *The University of Pennsylvania Law Review*).

Pervasive medical uncertainty could be expected to cause random practice pattern variations that evened out as physicians followed their individual subjective inclinations and values. Evidence of extremely wide practice style variations among regions, then, suggests that doctors "tend to follow what is considered standard and accepted in the community." Eddy, *supra* note 179, at 86.

¹⁸⁴ See J. EISENBERG, *supra* note 33, at 103; see also E. FREIDSON, *supra* note 48, at 182-83 ("Much of what is called patient management . . . is not sustained or chosen by any systematic scientific knowledge, but rather by personal preference and experience and by occupational custom and folklore."); D. MECHANIC, *THE GROWTH OF BUREAUCRATIC MEDICINE* 107-11 (1976) (describing medical socialization process); Luft, *Economic Incentives and Clinical Decisions*, in *THE NEW HEALTH CARE FOR PROFIT*, *supra* note 54, at 118-120 (discussing traditional models of clinical decision-making and economic factors affecting them); Morreim, *supra* note 76, at 37 (physicians are guided by informal protocols which are formed in routine clinical practice but are not always scientifically validated); Wong & Lincoln, *supra* note 70, at 2511 (reliance on routine as a factor contributing to the overuse of laboratory tests). This acting out of rules of thumb is sometimes referred to as "heuristic decisionmaking." Brannigan & Dayhoff, *supra* note 163, at 21-22.

influenced by severe resource constraints to adopt a far less aggressive style of medicine in the face of the same state of medical science.¹⁸⁵ The most effective motivational force is likely to be financial incentive. If fee-for-service or cost-based reimbursement is seen as the source of health care's excesses, reversing financial incentives to reward physicians for less rather than more treatment can be expected to change practice styles across the board. Structuring financial rewards can be a powerful control technique because this is a single intervention that has a continuing, decentralized influence on the universe of individual treatment decisions.¹⁸⁶

2. HMO and Hospital Financial Incentive Plans

Financial incentives are used to shape the practice patterns in both the HMO and the hospital industry. There are two primary structural forms of incentives: plans that reward physicians based on their individual levels of performance and plans that reward groups of physicians for their combined performance.

HMOs best illustrate the variety of ways in which health care institutions attempt to induce more economical practice through financial incentives.¹⁸⁷ HMOs are worthy of careful study because of the substantial savings potential they have demonstrated. HMO physicians hospitalize their patients as much as 40% less than the norm with little accompanying increase in the amount of ambulatory care.¹⁸⁸ A different

¹⁸⁵ See generally H. AARON & W. SCHWARTZ, *THE PAINFUL PRESCRIPTION* (1984) (comparing the levels of health care in Great Britain and the United States).

¹⁸⁶ One need not assume that physicians consciously act from economic motives to believe that reversing financial incentives will change physician behavior. It is only necessary to concede that the background financial framework for medical decisionmaking creates an environment that tends to foster one type of behavior over another. As Harold Luft explains in the context of HMO bonus plans:

[I]t is extremely unlikely that HMO physicians reflect upon the impact on their bonuses each time they consider a follow-up visit or an extra test. Instead, certain routine patterns are probably developed that tend to be consistent with their economic incentives. Inconsistent patterns may be re-examined and slowly adjusted to reduce conflict with system incentives.

Luft, *Health Maintenance Organizations and the Rationing of Medical Care*, 60 MILBANK MEM. FUND Q. 268, 275 (1982); see also Luft, *supra* note 184, at 103, 118 (questioning the degree to which economic incentives affect physicians' conscious decisions about medical treatment).

¹⁸⁷ This Article does not attempt to cover the universe of financial incentives for cost containment. In addition to the types discussed in this section, some HMOs operate under a capitation form of payment, whereby individual physicians are paid a flat rate per patient for the year. Traditionally, surgeons are also paid a flat fee per case. See J. EISENBERG, *supra* note 33, at 132.

¹⁸⁸ See Epstein, Begg & McNeil, *The Use of Ambulatory Testing in Prepaid and Fee-For-Service Group Practices*, 314 NEW ENG. J. MED. 1089, 1089 (1986) (50 per-

form of financial incentive typifies each of the two basic forms of HMOs: the group model, in which physicians practice together in the same setting, and the individual practice association ("IPA") model, a contractual association of a larger number of doctors who maintain solo practices in their individual offices.¹⁸⁹ Group HMOs usually employ their physicians on a salaried basis and sometimes are owned by the doctors themselves. IPAs typically compensate their physicians on a discounted fee-for-service basis, supplemented by bonuses for efficient performance or reduced by penalties for inefficiency.¹⁹⁰

Many health policy analysts maintain that salaried employment is the optimal form of physician reimbursement. A fixed salary neutralizes the distorting financial incentives inherent in fee-for-service payment but does not penalize careful and thorough treatment. Unfettered by financial pressures toward either overutilization or underutilization of medical resources, physicians are free to exercise their best medical judgment.¹⁹¹

However, when the physicians' "best medical judgment" has been schooled in the fee-for-service mode of treatment, physicians accustomed to a fee-for-service practice style can be expected to continue the same practices even if inflationary financial incentives are removed. Therefore, it is not clear that salaried compensation is the source of HMO success. More likely, HMO practice styles are moderated by group financial incentives. If doctors have an ownership interest in their HMO, profit distributions are awarded based on the group's effi-

cent fewer electrocardiograms and 40 percent fewer chest radiographs); Manning, Leibowitz, Goldberg, Rogers & Newhouse, *A Controlled Trial of the Effect of Prepaid Group Practice on Use of Services*, 310 NEW ENG. J. MED. 1505, 1505 (1984) (40 percent less hospitalization). The evidence concerning ambulatory costs is somewhat inconclusive because HMO patients seek more preventive care such as annual check-ups, but the intensity of service during HMO ambulatory visits is lower. See *id.*

¹⁸⁹ There are several variations of these basic forms so that the full list of HMO models is somewhat longer, distinguishing between staff and group models, and between traditional IPAs and network models. See generally H. LUFT, HEALTH MAINTENANCE ORGANIZATIONS: DIMENSIONS OF PERFORMANCE 4-6 (1981) (describing HMOs in general and listing several types); R. SHOULDICE & K. SHOULDICE, MEDICAL GROUP PRACTICE AND HEALTH MAINTENANCE ORGANIZATIONS 12-17 (1978) (explaining operation of diverse types of HMOs); Welch, *The New Structure of Individual Practice Associations*, 12 J. HEALTH POL. POL'Y & L. 723, 724-25, 729-30 (1987) (describing two types of HMOs).

¹⁹⁰ The form of financial incentive is not necessarily a definitional aspect of the HMO model. Rather, different types of HMOs have tended to rely on different compensation arrangements. This Article's focus on the most typical arrangements should not obscure the important experimentation that is taking place in the HMO industry. For example, IPAs are beginning to experiment with capitation payments to their physicians. See Ginsburg & Hackbarth, *supra* note 24, at 12; Welch, *supra* note 189, at 727-29.

¹⁹¹ See H. LUFT, *supra* note 189, at 353.

ciency. If group doctors are employed, then they realize that the institution's financial health affects the likelihood of receiving raises or bonuses.

Individual Practice Associations illustrate how financial incentives can be focused even more directly on physician performance. IPAs were pioneered by the medical profession in the 1970s as a response to the classic HMO format. Not surprisingly, IPAs attempt to preserve fee-for-service reimbursement. To be competitive, these organizations must devise some means to eliminate wasteful treatment. The IPA innovation was to create a bonus/penalty system that makes physicians partially at risk for the costs of care.

The essential concept is to allow physicians to retain a portion of the savings they generate when they avoid referrals to hospitals or outside specialists. There are a number of variations on this theme. For example, to pay for specialist and hospitalization charges, one IPA established an account for each physician consisting of a percentage of the premiums paid by that physician's patients. Each physician received half of any surplus that remained in her bonus pool and contributed half of any deficit, up to ten percent of the her HMO revenue.¹⁹² Physicians thus were directly rewarded for economizing and penalized for overspending.¹⁹³

¹⁹² See Palay, *Organizing an HMO by Contract: Some Transaction Cost Considerations*, 65 NEB. L. REV. 728, 733 & n.11 (1986); see also U.S. GENERAL ACCOUNTING OFFICE, PHYSICIAN INCENTIVE PAYMENTS BY PREPAID HEALTH PLANS COULD LOWER QUALITY OF CARE, REPORT TO THE CHAIRMAN, SUBCOMMITTEE ON HEALTH, HOUSE COMMITTEE ON WAYS AND MEANS 3-5, 24 (1988); Meier & Tillotson, *Physician Reimbursement and Hospital Use in HMOs*, 29-33 (U.S. Dept. Health, Educ., & Welfare, Health Care Financing Research & Demonstration Series, Rep. No. 8) (1978) (finding that physicians in IPAs who had suffered financial losses tightened controls); Egdahl & Taft, *Financial Incentives to Physicians*, 315 NEW ENG. J. MED. 59, 60 (1986) (predicting the trend toward the use of strong financial incentives to encourage efficient practice because education alone is not effective); Long, *An Integrated Theory of Provider Behavior in Health Maintenance Organizations*, 8 J. COMMUNITY HEALTH 119, 124-26 (1982) (comparison of IPA to staff model HMO suggests that effect of controls on provider behavior is a function of the magnitude of perceived risk rather than a result of the type of HMO); Welch, *supra* note 189, at 727-28 (contrasting foundation IPAs, where the risk pool is composed of all physicians in the group, with modern IPAs, where the risk pool is comprised of either an individual physician, or a small group of physicians).

¹⁹³ There are conflicting reports on the number of IPAs employing such direct bonus techniques. One study shows use by 87 percent while another shows only 20 percent. See McIlrath, *Impact of MD Incentives on Patient Care is Uncertain*, AM. MED. NEWS, Feb. 12, 1988, at 3, 25.

Poolled bonus techniques are also used by group HMOs, but on a less direct basis. The entire group is rewarded or penalized based on its overall performance. See Hillman, *Financial Incentives for Physicians in HMOs*, 317 NEW ENG. J. MED. 1743, 1744 (1987). The Group Health Association of America, the HMO industry's trade organization, reports that about 85 percent of its members use risk pools of one form or

Hospitals have also instituted efficiency bonus plans similar to those used by IPAs. The plan that has received the most attention was that implemented for a brief time by the Paracelsus Corporation chain of hospitals in California in response to the Medicare DRG reimbursement method. The Paracelsus DRG incentive plan paid each member of the medical staff a percentage of the profits the hospital earns from that physician's Medicare patients.¹⁹⁴ Hospitals can also reward profitable physicians with certain in-kind or fringe benefits.¹⁹⁵ Blue Cross and Blue Shield plans are implementing analogous arrangements on both an outpatient and inpatient basis. The Massachusetts plan pays obstetricians a bonus for shortening the length of stay for vaginal childbirth, and the North Carolina plan pays bonuses for performing certain procedures outside of the hospital.¹⁹⁶

Evaluation of the performance of these various financial incentives is difficult because of the sparsity of hard evidence on the effectiveness of cost decreasing¹⁹⁷ incentives.¹⁹⁸ The best controlled study offered

another. *HHS Ponders Tying MD Incentives to HMO/CMP Review*, HOSPITALS, May 5, 1987, at 55.

¹⁹⁴ See U.S. General Accounting Office, Physician Incentive Payments by Hospitals Could Lead to Abuse, Report to the Chairman, Subcommittee on Health, House Committee on Ways and Means 14 (1986) [hereinafter GAO REPORT]. For purposes of computing the profit margin, Paracelsus considered its costs to be 70 or 75 percent of its charges. The bonus percentage escalated from 10 to 20 percent as the profit margin increased. See *id.* & n.1

An incentive plan proposed by another hospital works as follows. Each physician has an "efficiency index" that is determined by debits and credits earned for each patient treated. Debits and credits are awarded according to whether the patient is discharged within the mean length of stay and whether ancillary service use is below the norm for that patient's condition. Each physician's index then determines her share of the hospital cost savings, to be paid only upon the physician's retirement or death. Only physicians with a certain level of admissions are eligible to participate. See Tatge, *Illinois Hospital Awaits IRS Ruling on Prototype Physician Incentive Plan*, 14 MOD. HEALTH CARE, June 1984, at 23, 23-24.

¹⁹⁵ Examples of perquisites that hospitals sometimes provide to their favored physicians on a partially or fully subsidized basis include: pharmaceuticals, office space and secretarial services, medical education seminars, billing and collection services, construction loans, and joint venture opportunities. See FOR-PROFIT ENTERPRISE IN HEALTH CARE, *supra* note 34, at 166 n.7. One in-kind benefit that is particularly attractive in this context is malpractice insurance because it has the added effect of diminishing the defensive medicine concerns that might thwart efficiency incentives.

¹⁹⁶ See Egdaahl & Taft, *supra* note 192, at 60.

¹⁹⁷ It is of course well known that cost *increasing* incentives have an effect, but those incentives work in favor of rather than against quality of care. See *supra* note 6.

¹⁹⁸ See J. EISENBERG, *supra* note 33, at 133, 134 (arguing that financial incentives never "given a reasonable chance" because of "politically motivated objections"); Fineberg, Funkhouser & Marks, *Variation in Medical Practice: A Review of the Literature*, in HEALTH CARE MANAGEMENT AND MEDICAL PRACTICE PATTERNS 143, 156-57 (R. Egdaahl & D. Walsh eds. 1985); Myers & Schroeder, *Physician Use of Services for the Hospitalized Patient: A Review, with Implications for Cost Containment*, 59 MILBANK MEM. FUND Q. 481, 501 (1981) (stating that data on effectiveness

medical residents textbook and journal subscription vouchers worth about \$200 for reducing their test ordering.¹⁹⁹ That this award had no effect is hardly surprising given its parsimonious size and its patronizing content.²⁰⁰ Likewise, anecdotal reports that financial incentives have remarkably little effect on HMO physician performance²⁰¹ are explained by the fact that the financial risk or reward is not large enough to be noticed.²⁰²

of incentives are "fragmentary and preliminary"); Schroeder, *Strategies for Reducing Medical Costs by Changing Physicians' Behavior*, 3 INT'L J. TECH. ASSESSMENTS IN HEALTH CARE 39, 44 (1987) (finding that evidence of efficacy of cost containment strategies contradictory). One study that attempts to fill this void reports favorably on financial incentives. See Welch, *supra* note 189, at 723.

¹⁹⁹ See Martin, Wolf, Thibodeau, Dzau & Braunwald, *A Trial of Two Strategies to Modify the Test-Ordering Behavior of Medical Residents*, 303 NEW ENG. J. MED. 1330, 1331 (1980).

²⁰⁰ See J. EISENBERG, *supra* note 33, at 133 ("token" rewards induce token responses); Schroeder, *supra* note 198, at 44 ("trivial" rewards). A later attempt to duplicate this experiment failed because the residents objected to participating in a program with "demeaning" financial inducements. See Eisenberg & Williams, *supra* note 33, at 13.

²⁰¹ See, e.g., FOR-PROFIT ENTERPRISE IN HEALTH CARE, *supra* note 34, at 166 n.7 (despite lack of systematic studies, HMO officials indicated that bonus system did not significantly affect utilization); H. LUFT, *supra* note 189, at 356 (effect of financial incentives on physician behavior is only indirect); Long, *supra* note 192, at 124-26 (study comparing foundation HMOs with fee-for-service equivalents and finding no difference in hospital utilization); Meier & Tillotson, *supra* note 192, at 40 (HMO physicians interviewed felt that financial risk did not alter their practice patterns). One suspects, however, that these reports may be influenced by a desire to avoid any accusation that HMO physicians unethically profit by withholding necessary treatment.

²⁰² Traditionally, HMO patients have constituted only a small percentage of the patient base for IPA physicians. Therefore, even a sizeable bonus has little impact on the physicians' overall incomes. See J. EISENBERG, *supra* note 33, at 133 (noting "remote relationship between the doctors' own practice, the HMO balance sheet, and doctors' bonuses"); H. LUFT, *supra* note 189, at 356 (citing Meier and Tillotson study that indicates physicians in HMOs generally bear a low level of financial risk); Meier & Tillotson, *supra* note 192, at 40, 71-72 (noting that "none of the physicians interviewed had more than 10 percent of their total income directly at risk, and most far less than that"). The potential loss of 10 to 15 percent of HMO receipts is even more inconspicuous considering that physicians generally do not expect to collect 100 percent of their billings. See *id.* at 19-20 (physicians noted that collection rates on their fee-for-service practices were 90-92 percent and that a risk of less than 10 percent would be comparable to a bonus). For IPA physicians, then, it has not been shown that financial incentives have no effect, only that the incentives are not large enough to be felt. See *id.* at 71-72 ("It is not known what effect 30 to forty percent risk may have on a physician.").

More recent forms of IPAs with a higher concentration of HMO patients and a larger incentive percentage demonstrate more favorable results. See Berenson, *In a Doctor's Wallet*, NEW REPUBLIC, May 18, 1987, at 11, 12 (stating that "under a typical HMO 'risk' payment system, take-home annual income might vary by \$65,000 or more."); Hillman, *supra* note 193, at 1747 (as percentage of patients enrolled in HMO and percentage of income at risk increase, incentives become increasingly important to physicians); Welch, *supra* note 189, at 727-28 (noting that in large IPAs, about one-third of a physician's practice is now capitated and 20-30 percent of the physicians fee

On balance, the use of financial inducement to counteract the inflationary incentives of fee-for-service reimbursement offers a promising avenue for reform even though the precise effects are not well understood. There have been important innovations in the use of efficiency incentives, but full study and development have been deterred by the ethical sensitivity that surrounds overt acknowledgement of financial inducement in health care. Exploratory efforts not blocked by professional resistance have been somewhat timid, and those fully implemented are clouded by the subdued nature of the reports of success.

B. *An Overview of Fee Splitting Prohibitions*

Institutional cost containment techniques that rely on financial incentives must contend with a group of federal and state statutory prohibitions against medical fee splitting. A hospital or HMO that distributes part of its receipts to doctors as an incentive for efficient practice can be accused of illegally splitting its fees with the doctors.²⁰³ There are two sets of fee splitting statutes: one is focused principally on fee splitting as an inducement to treat (referral fees) and the other on fee splitting as an inducement not to treat (antireferral fees).

The most threatening referral fee prohibition is the federal Medicare/Medicaid fraud and abuse statute, which, paraphrased, declares that anyone who pays or receives any remuneration directly or indirectly, overtly or covertly, in cash or in kind for the referral of a patient to a person for the furnishing of any item or service for which payment may be made under Medicare or Medicaid is guilty of a felony punishable by five years imprisonment or \$25,000, or both.²⁰⁴ Many states also directly criminalize referral fees,²⁰⁵ and medical practice acts frequently enumerate the payment of referral fees as one of the grounds

is withheld).

²⁰³ More pejoratively, the payment might be characterized as a kickback or rebate.

²⁰⁴ See 42 U.S.C. § 1395nn(b) (1982). Many state codes duplicate this provision with respect to their Medicaid programs. See, e.g., IND. CODE ANN. § 12-1-7-28.2 (West 1982); MASS. GEN. LAWS ANN. ch 118E, § 21B (West Supp. 1988).

²⁰⁵ See, e.g., CAL. BUS. & PROF. CODE § 650 (West Supp. 1988); CAL. HEALTH & SAFETY CODE § 445 (West 1979); COLO. REV. STAT. § 12-36-125 (1985); FLA. ANN. STAT. § 395.0185 (West 1986); ILL. ANN. STAT. ch. 23, para. 8A-3(b)(1) (Smith Hurd 1988); MICH. COMP. LAWS ANN. § 28.683, sec. 428 [750.428] (1982); TENN. CODE ANN. § 39-6-1202 (West 1982); TEX. REV. CIV. STAT. ANN. art. 4495b, § 3.07(c) (Vernon Supp. 1988); VA. CODE ANN. § 54-278 (1982); WIS. STAT. ANN. § 448.08 (West 1988). California's statute, which has received the most discussion, states, "[T]he . . . receipt or acceptance, by any [physician] of any rebate, refund, commission . . . or other consideration, whether in the form of money or otherwise, as compensation or inducement for referring patients . . . to any person . . . is unlawful." CAL. BUS. & PROF. CODE § 650 (West Supp. 1988).

for revocation or suspension of a physician's license to practice.²⁰⁶

These statutes are directed at fee splitting as an inducement to order services. A new federal statute, part of the Omnibus Budget Reconciliation Act of 1986²⁰⁷ ("OBRA 1986"), is directed in precisely the opposite direction: at cost containment incentive plans that share fees in order to *reduce* services. It allows the Department of Health and Human Services to assess civil monetary penalties of up to \$2000 against a hospital that "makes a payment, directly or indirectly, to a physician as an inducement to reduce or limit services provided with respect to [Medicare or Medicaid patients] who . . . are under the direct care of the physician."²⁰⁸ This prohibition of efficiency incentives is scheduled to extend to HMOs as well beginning April 1, 1990.²⁰⁹

Because there is little authoritative interpretation of the meaning and application of these varied and complex statutes, determining the validity of a fee splitting accusation is no simple matter. One must iron out the interpretational wrinkles before taking a broader policy perspective. This discussion, therefore, first assesses whether the fee splitting concept, as it has been developed in various legal interpretations, *in fact* fits financial cost containment incentives. It then assesses whether this concept *should* fit such incentives. Two different forms of financial incentives will be examined: individual physician plans and group incentive plans.

²⁰⁶ See, e.g., ALA. CODE § 34-24-360(10) (Supp. 1987); D.C. CODE ANN. § 2-3305.14(a)(14) (1988); FLA. STAT. ANN. § 458.331(1)(j) (West Supp. 1988); GA. CODE ANN. § 43-34-37(a)(9) (Supp. 1987); KAN. STAT. ANN. § 65-2837(b)(19) (Supp. 1987); KY. REV. STAT. ANN. § 311.595(18) (Michie 1983); MD. HEALTH OCC. CODE ANN. § 14-504(16) (Supp. 1987); MICH. COMP. LAWS ANN. § 333.16221(d)(ii) (West 1988); MINN. STAT. ANN. § 147.091(1)(p) (West Supp. 1988); NEB. REV. STAT. § 71-148(3) (1988); NEV. REV. STAT. ANN. § 630.305(2) (Michie Supp. 1988); N.M. STAT. ANN. § 61-6-14(B)(16) (1986); N.Y. EDUC. LAW § 6509-a (McKinney 1985); OHIO REV. CODE ANN. § 4731.22(B)(17) (Anderson 1987); R.I. GEN. LAWS § 5-37-5.1(12) (1987); S.D. CODIFIED LAWS ANN. § 36-4-30(10) (1986); TENN. CODE ANN. § 63-6-214(16) (1986); VT. STAT. ANN. tit. 26, § 1354(12) (Supp. 1987); W. VA. CODE § 30-3-14(c)(6) (1986); WIS. STAT. ANN. § 448.08(1) (West 1988).

A typical statute allows disciplinary action by the board of medical examiners for "division of fees . . . received for professional services with any person for bringing or referring a patient." See, e.g., ALA. CODE § 34-24-360(10) (Supp. 1987); D.C. CODE ANN. § 71-148(3) (1988); R.I. GEN. LAWS § 5-37-5.1 (1987); VT. STAT. ANN. tit. 26, § 1354(12) (Supp. 1987).

²⁰⁷ Pub. L. No. 99-509, 100 Stat. 2003 (1986) (codified at 42 U.S.C.A. § 1320a-7a(b) (West Supp. 1988)).

²⁰⁸ 42 U.S.C. § 1320a-7a(b)(2) (West Supp. 1988). The penalty also extends to doctors who receive such payments.

²⁰⁹ Pub. L. No. 100-203, § 4016 (1987), (codified at 42 U.S.C. § 1320a-7a (West Supp. 1988)).

C. Individual Physician Plans

The recent Congressional prohibition of efficiency incentives clearly prohibits arrangements, such as Paracelsus' DRG plan, that pay individual physicians for reducing services.²¹⁰ However, this antireferral fee statute provides only modest civil penalties in contrast to the severe licensure and felony sanctions that follow from referral fee statute violations. Moreover, HMOs are not presently covered by the new prohibition, and there is some question whether the scheduled extension to them will ever occur.²¹¹ The more pressing concern, therefore, is the legality of efficiency incentives under conventional referral fee statutes.

Although individual physician incentive plans involve the splitting with physicians of the hospitals' and HMOs' fees,²¹² the Medicare/

²¹⁰ Note, however, three possible escape routes. One is to base rewards on something other than the "reduc[tion] or limit[ation] of services." A hospital might reward physicians who substitute certain lower cost modes of treatment, for example, an X-ray rather than a CAT scan, in certain defined situations. Dechene, *Physician Incentive Programs: Are They Legal?*, HEALTH SPAN, Jan. 1987, at 3, 9. This would create serious concerns under the fraud and abuse and referral fee statutes, however, because the payments would be directly related to the number of tests ordered. Also, such specific directions backed by economic sanctions raise concerns about interference with the practice of medicine. See *supra* notes 76-146 and accompanying text.

Another possible escape route is to design plans that apply only to hospital-based physicians, such as radiologists and anesthesiologists, who do not have independent relationships with their patients. The legislative history explicitly states that "[t]he prohibition . . . would not apply to a physician who provides ancillary services under contract to a hospital." COMMITTEE ON THE BUDGET, OMNIBUS BUDGET RECONCILIATION ACT OF 1986, H.R. 5300, H.R. REP. NO. 727, 99TH CONG., 2D SESS. 445, reprinted in 1986 U.S. CODE CONG. & ADMIN. NEWS 3607, 3842 [hereinafter H.R. REP. NO. 727]. The theory is that payments to such physicians do not meet the requirement of being related to patients who "are under the direct care of the physician." 42 U.S.C.A. § 1320a-7a(b)(1)(C) (West Supp. 1988); see Dechene, *supra*, at 7.

This rationale is not wholly convincing. Although hospital-based physicians are not the primary or attending doctor, they render direct care, as do consulting physicians. Perhaps a better explanation is that some (but not all) ancillary care physicians do not determine the quantity of services. X-rays, for instance, are typically ordered by the treating physician and only performed by the radiologist. This simply establishes, however, that it would be moot to target such nonordering physicians. The same House Report notes a more promising escape route:

It is the Committee's intent that the prohibition not apply to hospital incentive arrangements with physicians who have a management or supervisory responsibility with respect to the operation of a hospital department . . . insofar as the purpose of the arrangement is limited to encouraging efficiency in the operation of the department.

H.R. REP. NO. 727, *supra*, at 445.

²¹¹ See *supra* note 248 and accompanying text.

²¹² The fact that these plans involve payments by institutions rather than by physicians might raise a possible defense because some of the state statutes are directed only at physicians. See *supra* note 206. However, these statutes have been interpreted

Medicaid fraud and abuse statute and the classic forms of the state disciplinary and criminal fee splitting statutes do not appear to reach these arrangements.²¹³ These provisions generally prohibit fee division for the referral of patients. Hospital and HMO incentive payments, in sharp contrast, are intended to *reduce* treatment. These *antireferral* fees are earned by *not* recommending treatment, by *not* hospitalizing, and by *not* referring to specialists. Efficiency incentives combat precisely the evil that referral fee prohibitions target: inflated charges and overutilization. Thus, on first encounter, the referral fee concept does not appear to apply to these plans.²¹⁴

The analysis is more complex than this, however. Incentive plans can have a secondary effect that counters their primary antireferral

as proscribing fee splitting generally, either under the theory that the institution is aiding and abetting in the enterprise, *see* 16 Cal. Op. Att'y Gen. 18, 27 (1950), or under the theory that the statute expresses a general public policy against fee splitting. *See* *State v. Abortion Information Agency, Inc.*, 37 A.D.2d 142, 144, 330 N.Y.S.2d 927, 929 (1971), *aff'd*, 30 N.Y.2d 779, 285 N.E.2d 317, 337 N.Y.S.2d 174 (1972).

²¹³ To the extent that incentive plans rely on in-kind benefits rather than cash payments, *see supra* note 195, they are even easier to defend because some state statutes appear only to prohibit the payment of monetary referral fees, in contrast with those statutes that broadly prohibit any form of compensation. The following statutes have the narrower proscriptions: ALA. CODE § 34-24-360(10) (Supp. 1987); COLO. REV. STAT. § 12-36-125 (1985); GA. CODE ANN. § 43-34-37(a)(9) (Supp. 1987); IND. CODE ANN. § 12-1-7-28.2 (West 1982); MD. HEALTH OCC. CODE ANN. § 14-504(16) (Supp. 1987); MICH. COMP. LAWS ANN. § 333.16221(d)(ii) (West Supp. 1988); MINN. STAT. ANN. § 147.091(1) (West Supp. 1988); NEB. REV. STAT. § 71-148(3) (1986); NEV. REV. STAT. ANN. § 630.305(2) (Michie Supp. 1988); OHIO REV. CODE ANN. § 4731.22(B)(17) (Anderson 1987); R.I. GEN. LAWS § 5-37-5.1(12) (1987); TENN. CODE ANN. § 63-6-214(16) (1986).

²¹⁴ Most commentators who have considered the legality of hospital incentive plans agree. *See* GAO REPORT, *supra* note 194, at 9, 12, 24; *see also* Dechene, *supra* note 210, at 6 (reporting that the California Board of Medical Quality Assurance has ruled that hospital incentive plans do not violate the California referral fee statute); Reiss & Ward, *Medicare Fraud and Abuse Issues Involving Alternative Delivery Systems*, TOPICS IN HOSP. L., June 1986, at 13, 17 ("It is unlikely that Congress would have intended the [federal statute] to cover such cost-reducing incentives."); N.Y. Times, Sept. 24, 1985, at 12, col. 1 (reporting that the HHS Inspector General "finds [the Paracelsus plan] worrisome, although probably not illegal"). *But see* FOR-PROFIT ENTERPRISE IN HEALTH CARE, *supra* note 34, at 161; GAO REPORT, *supra* note 194, at 15, 16 (Paracelsus plan may be illegal); Weissburg & Stern, *Can Hospitals Reward Physicians for Reducing Unnecessary Utilization?*, FED. AM. HOSP. REV., Sept.-Oct. 1985, at 45, 46 (stating that "hospitals that proceed with incentive compensation programs do so at some risk").

Almost no attention has been paid to HMO incentive plans. This may reflect the legality of a view that fee splitting is implicitly approved by the HMO enabling acts in many states because it is so central to their manner of operation. *See infra* note 248. This reasoning is supported by *Albany Medical College v. McShane*, 66 N.Y.2d 982, 489 N.E.2d 1278, 499 N.Y.S.2d 376 (1985), which addressed a fee splitting challenge to a typical faculty compensation arrangement at a teaching hospital. The court reasoned that the division of hospital receipts among faculty physicians was implicitly sanctioned by the legislative grant of authority to operate a teaching hospital. *Id.* at 993, 489 N.E.2d at 1279, 499 N.Y.S.2d at 377.

purpose.²¹⁵ In order for physicians to profit from an incentive plan, they must admit their patients to the hospital (in the case of a DRG plan) or enroll them with the HMO (in the case of an IPA plan). As a result, these plans potentially violate one of the primary purposes of fee splitting prohibitions, namely, to eliminate financial influence on a doctor's choice of the source of care. DRG plans, for instance, might induce doctors to direct their Medicare patients to the hospital with the most advantageous DRG bonus plan. This secondary incentive would be even more obvious under a plan that pays efficiency awards so indiscriminately that doctors would receive payments virtually in proportion to their hospital admissions.

Subsidiary referral incentives underlying physician payments for nonreferral services have formed the basis for criminal convictions in other contexts. In the most prominent example, *United States v. Greber*,²¹⁶ the federal government successfully prosecuted the owner of a cardiology diagnostic laboratory for violating the Medicare/Medicaid fraud and abuse statute by paying "interpretation fees" to referring physicians, ostensibly as compensation for evaluating the diagnostic data produced by laboratory tests. The court rejected the defense's contention that "compensating a physician for services actually rendered could not be a violation of the statute," reasoning in terms that appear to consider *any* secondary referral incentive as a potential felony offense.²¹⁷ *Greber* casts serious doubt on the legality of individual physi-

²¹⁵ In addition to this complication, not all of the state statutes speak in terms of fee splitting for referrals. Some proscribe fee splitting in the abstract, without mention of the purpose of the splitting. See ILL. ANN. STAT. ch. 23, para. 8A-3(b)(1), (c)(1), (d)(3) (Smith-Hurd 1988); N.Y. EDUC. LAW § 6509-a (McKinney 1985); OHIO REV. CODE ANN. § 4731.22(B)(17) (Anderson 1987); TENN. CODE ANN. § 63-6-214(16) (1986). Others prohibit any payment of professional fees for medical services not actually rendered. See KAN. STAT. ANN. § 65-2837(b)(19) (Supp. 1987); KY. REV. STAT. ANN. § 311.595(18) (Michie/Bobbs-Merrill 1983); NEV. REV. STAT. ANN. § 630.304(2) (Michie Supp. 1988).

²¹⁶ 760 F.2d 68 (3d Cir.), *cert. denied*, 474 U.S. 988 (1985), discussed in Roble & Mason, *The Legal Aspects of Health Care Joint Ventures*, 24 DUQ. L. REV. 455, 465-66 (1985); Comment, *The Medicare-Medicaid Anti-Fraud and Abuse Amendments: Their Impact on the Present Health Care System*, 36 EMORY L.J. 691, 721-24 (1987) [hereinafter Comment, *Medicare-Medicaid Anti-Fraud*]; Comment, *United States v. Greber: A New Era in Medicare Fraud Enforcement?*, 3 J. CONTEMP. HEALTH L. & POL'Y 309, 319 (1987); Comment, *United States v. Greber and its Effect on the Medicare and Medicaid Programs*, 75 KY. L.J. 677, 693-94 (1987).

²¹⁷ It stated,

Even if the physician performs some service for the money received, the potential for unnecessary drain on the Medicare system remains. The statute is aimed at the inducement factor.

The text refers to "any remuneration." That includes not only sums for which no actual service was performed but also those amounts for which some professional time was expended. "Remunerates" is defined as

cian incentive plans under the various referral fee prohibitions.²¹⁸ Despite the plans' obvious beneficial effects, no easily identifiable or sufficiently reliable principle exists to excuse their literal illegality.²¹⁹

D. Joint Ventures and Other Group Incentive Plans

1. Examples

Institutions can also structure cost containment incentives for a group of doctors. For example, some HMOs pay their doctors a bonus based on the group's overall performance.²²⁰ Even without an explicit bonus, salaried HMO physicians are influenced by their realization that the group's performance affects the likelihood of receiving future raises. Like HMOs, hospitals also can create group incentives through techniques that align physicians' economic interests with those of the institution. The most direct method gives physicians an ownership interest in the institution. This approach is exemplified by the dying breed of physician-owned hospitals, the emerging breed of group-owned HMOs, and the resurging breed of physician-owned outpatient services.²²¹ Physician proprietary interest is a strong vehicle for cost containment under prospective payment because doctors realize that their profit distributions depend on the costs of their treatment

"to pay an equivalent for service." . . . That a particular payment was a remuneration (which implies that a service was rendered) rather than a kickback, does not foreclose the possibility that a violation nevertheless could exist.

. . . .
 . . . If the payments were intended to induce the physician to use [the laboratory's] services, the statute was violated, *even if the payments were also intended to compensate for professional services.*

Greber, 760 F.2d at 71-72 (citation omitted) (emphasis added); *see also* *Mason v. Hosta*, 152 Cal. App. 3d 980, 987, 199 Cal. Rptr. 859, 863 (1984) (referral fees prohibited "[n]o matter how subtly disguised, or ingeniously interpreted").

²¹⁸ *See, e.g., Adams & Klein, Medicare and Medicaid Anti-Fraud and Abuse Law: The Need for Legislative Change*, HEALTH SPAN, Jan. 1985, at 19, 22 ("[N]o absolute assurance can be given that a particular incentive arrangement will not ultimately be found to be illegal."). *Compare* Note, *Abusing the Patient: Medicare Fraud and Abuse and Hospital-Physician Incentive Plans*, 20 U. MICH. J.L. REF. 279, 287-95 (1986) (contending that incentive plans are illegal) with Comment, *Medicare-Medicaid Anti-Fraud*, *supra* note 216, at 735 (arguing that incentive plans are legal).

²¹⁹ For further analysis of *Greber* and the uncertainties of referral fee analysis in general, as well as in the specific context of physician incentive plans, see Hall, *Making Sense of Referral Fee Statutes*, 13 J. HEALTH POL. POL'Y & L. 623 (1988).

²²⁰ *See supra* text following note 190.

²²¹ Clinical laboratories, ambulatory surgery centers, minor emergencies facilities, and outpatient diagnostic clinics are representative of the latter category. *See generally* *Are Physician Labs a Competitive Threat?*, HOSPITALS, Apr. 20, 1987, at 96, 96 (examining physician office labs); Droste, *Freestandings Bound to Gain Under New PPS Plan*, HOSPITALS, July 5, 1987, at 60, 60-61 (discussing ambulatory surgery centers).

decisions.²²²

One modern adaptation of the physician-ownership concept, pioneered at Johns Hopkins, is to structure a hospital so that it consists of several firms within a firm. A hospital gives each of its departments its own budget and makes each accountable for its revenues and expenses. Each group of doctors thus has a stake in its department's performance.²²³ If the department is run efficiently, then the doctors have more to spend on new equipment and other amenities of practice. Any shortfalls are taken out of the succeeding year's budget.²²⁴

Hospital group incentive plans are being discussed in a variety of other forms. DRG incentive plans can be constructed to reward the medical staff as a whole based the the hospital's overall performance

²²² Although speculatively promising, there has been no careful study of the actual efficiency effects of physician ownership. One anecdotal discussion of HMOs reported that physician proprietary interest has little effect on the awareness of financial risk. This finding is tempered by the realization that significant at-risk ownership is rare. The risks of ownership are usually diffused through a large group of doctors or the doctors are backed by guarantees from a sponsoring organization. See Meier & Tillotson, *supra* note 192, at 21-22.

²²³ See Heyssel, Gaintner, Kues, Jones & Lipstein, *Decentralized Management in a Teaching Hospital*, 310 NEW ENG. J. MED. 1477, 1477-80 (1984) [hereinafter Heyssel] (discussing the Johns Hopkins management structure). For a favorable discussion of departmental organization, see, e.g., D. YOUNG & R. SALTMAN, *supra* note 169, at 162-69 (evaluating performance of a well-operated management system); Harris, *supra* note 29, at 97, 99 (discussing medical staff departments as internal cost centers); Shortell, *Physician Involvement in Hospital Decisionmaking*, in THE NEW HEALTH CARE FOR PROFIT, *supra* note 54, at 98-99 (discussing the benefits of physician involvement in decisionmaking).

An additional attraction is that this structure is capable of incorporating intersecting lines of authority through what is referred to in organization theory as a matrix design. See Kaluzny, *Design and Management of Disciplinary and Interdisciplinary Groups in Health Services: Review and Critique*, 42 MED. CARE REV. 77, 83-84 (1985); Neuhauser, *The Hospital as a Matrix Organization*, HOSP. ADMIN., Fall 1972, at 8, 19-25. The essential construct is, vertically, for departmental administrators to exercise financial authority over each department while, horizontally, physicians or physician teams are accountable for coordinating patient care in individual cases among the various departments. See *id.* at 19-21. Theorists contend that this model is capable of reconciling competing institutional demands, such as quality versus cost or bureaucratic control versus professional autonomy. See Scott, *supra* note 72, at 230 (discussing the possibilities of co-existence and interdependence).

Unfortunately, the reported results are modest at best. During an eight-year period at Johns Hopkins, costs increased at a rate of 10.5 percent, only slightly less than the 11 percent growth rate for all Maryland hospitals. See Heyssel, *supra*, at 1478. Another study found no evidence that formal departmental structure decreases hospital expenditures. See Sloan & Becker, *Internal Organization of Hospitals and Hospital Costs*, 18 INQUIRY 224, 236 (1981). Moreover, this departmental organization may be feasible only at very large hospitals, such as the 1000-bed Johns Hopkins. See Heyssel, *supra*, at 1477.

²²⁴ Hospitals can also structure DRG incentive plans to reward the medical staff as a whole based on the hospital's overall performance under Medicare. See GAO REPORT, *supra* note 194, at 16-18; Dechene, *supra* note 210, at 8-9.

under Medicare. More likely, hospitals will begin to form a variety of joint venture arrangements that give selected member physicians a type of proprietary interest in a limited aspect of the hospital enterprise, a less threatening approach to physician autonomy than other alternatives to the traditional medical staff.²²⁵ Hospital/physician joint ventures of assorted shapes and sizes are receiving enthusiastic promotion in the trade literature.²²⁶ The details of these proposals vary widely, but they share the same essential form: the hospital contracts with a group of doctors to provide hospital treatment; the joint venture then structures the group's reimbursement to reflect its efficiency.²²⁷ The venture can cover all hospital patients or only a portion of the business, such as that

²²⁵ See Glandon & Morrissey, *Redefining the Hospital-Physician Relationship Under Prospective Payment*, 23 INQUIRY 166, 169 (1986). Joint ventures offer many of the features of selective employment but in a structure that better preserves physician autonomy than the traditional staff model. Like employment, the hospital deals only with a select group of physicians under a group compensation arrangement that fosters efficiency. The group, however, has responsibility for all matters relating to physician selection, supervision, and internal compensation. See *id.* at 169-71, 174.

²²⁶ See, e.g., *id.* at 170-71 (describing some of the benefits of joint ventures). An entertaining byproduct of this discussion is a renewal of health care's longstanding Battle of the Acronyms. Ever since the early 1970s when Paul Ellwood and his associates championed the term "health maintenance organization" for what had previously been referred to more descriptively as simply prepaid group practice, see P. ELLWOOD, JR., N. ANDERSON, J. BILLINGS, R. CARLSON, E. HOAGBERG & W. MCCLURE, *THE HEALTH MAINTENANCE STRATEGY 2* (1970), health policy analysts have fought to establish authorship of acronyms for newly emerging delivery systems. For example, *Hospitals* is insistent on changing the accepted term "preferred provider organization" ("PPO") to "preferred provider arrangement" ("PPA"). See *HOSPITALS*, Dec. 1, 1985, at 9, 9, 11 (Reader Feedback). Currently, the fiercest contest is that being waged in the conference circuit between Ellwood and health care lawyer Jack Wood over their respective joint venture plans. Ellwood's scheme is termed a "MeSH," short for Medical Staff/Hospital. See Ellwood, *When MDs Meet DRGs*, *HOSPITALS*, Dec. 16, 1983, at 62, 62-63. Wood's proposal is termed a "PHO" for physician/hospital organization. See Wood, *Health Trends, Medical Staff and PHO*, in *PRACTISING LAW INSTITUTE, HOSPITALS IN TODAY'S HEALTH CARE MARKETPLACE* 203, 210 (1985). These plans differ only in their particulars.

It is difficult to make informed predictions of the concrete success of joint ventures. The joint venture concept is so fluid and nonspecific that it covers a broad range of interactions. For example, the way in which many emergency rooms and radiology departments are presently organized could easily be characterized as a joint venture. See *Adamski v. Tacoma General Hosp.*, 20 Wash. App. 98, 108, 579 P.2d 970, 975 (1978) (describing a typical emergency room staffing arrangement in which hospital and physicians share profits). Truly novel arrangements are only occasionally implemented. See Morrissey & Brooks, *Hospital-Physician Joint Ventures: Who's Doing What*, *HOSPITALS*, May 1, 1985, at 74, 74 (noting that joint ventures exist at only 11.76% of hospitals). Joint venture proponents admit that some proposals to share equal power and exercise mutual influence are somewhat utopian concepts. See Scott, *supra* note 72, at 230. Nevertheless, these and other group incentive arrangements show promise and deserve careful legal analysis.

²²⁷ For further descriptions of joint ventures, see Aird & Skillicorn, *Physician Culture: A Forgotten Ingredient*, *FRONTIERS HEALTH SERVICES MGMT.*, Feb. 1985, at 49, 52-53; Glandon & Morrissey, *supra* note 225, at 169-71.

generated by a contract with a particular HMO.²²⁸ A joint venture might compensate physicians for the treatment itself or for some other package of services. One frequently mentioned technique is to pay the physician group for utilization review services based on the group's effectiveness in reducing the hospital's costs.²²⁹

2. Validity of Group Incentives

Group incentive plans are more likely than individual physician incentive plans to survive scrutiny under state and federal referral-fee law. Generally, the variety of arrangements encompassed by the joint venture are valid if the physician investment is not used as a proxy to reward the level of physician referrals. For instance, the California attorney general distinguishes between legal joint ventures that base distributions on the level of legitimate investment and illegal plans that pay physicians according to the amount of business the doctors generate.²³⁰ Similarly, the Department of Health and Human Services allows normal profit distributions to physicians based on a purchased ownership interest.²³¹

Unfortunately, group incentive plans may be no safer than individual incentive plans under the federal antireferral statute.²³² The re-

²²⁸ See Roble & Mason, *supra* note 216, at 455-56.

²²⁹ See Dechene, *supra* note 210, at 9.

²³⁰ See Cal. Op. Att'y Gen. No. 84-806, at 10 (Feb. 8, 1985); 16 Cal. Op. Att'y Gen. 18, 24 (1950).

²³¹ See Teplitzky, *Avoiding Fraud and Abuse Problems in Joint Ventures*, HEALTH SPAN, Jan. 1987, at 17, 20-21; Tillman, Miller & Bladen, *Overview of Fraud and Abuse Statutes and Regulations*, in MEDICARE FRAUD & ABUSE: UNDERSTANDING THE LAW 5, 10, 18 (J. Johnson & J. Seifert, eds. 1986).

Also, some state referral-fee statutes explicitly exempt physician referrals to institutions they own. See CAL. BUS. & PROF. CODE § 650 (West 1974 & Supp. 1988) (referrals permitted for valid medical reason); WASH. REV. CODE ANN. § 19.68.010 (West 1978) (referrals permitted with disclosure of financial interest); see also KAN. STAT. ANN. § 65-2837(19) (Supp. 1987) (definition of "unprofessional conduct" excludes acquiring fees through legal functioning of partnership); KY. REV. STAT. ANN. § 311.595(18) (Michie/Bobbs-Merrill 1983) (prohibition does not impair ability to practice in partnership); N.Y. EDUC. LAW § 6509-a (McKinney 1985) (same); WIS. STAT. ANN. § 448.08(4) (West 1988) (doctors' clinics may use single billings).

²³² Group plans may face an additional impediment under state and federal law. Some states proscribe physician referrals to institutions they own unless the patient knows of the possible conflict of interest. See CAL. BUS. & PROF. CODE § 654.2 (West Supp. 1988); WASH. REV. CODE ANN. § 19.68.010 (1978). A few states prohibit such referrals altogether. See, e.g., MICH. COMP. LAWS ANN. § 333.16221(e)(iv) (West Supp. 1988) (referral to an institution in which the physician has a financial interest constitutes unprofessional conduct); Teplitzky, *supra* note 231, at 18 (Pennsylvania bans self-referrals within the Medicaid program). On the federal level, Representative Fortney Stark (D-CA) introduced a bill in the last Congress that would prohibit physicians from referring patients for Medicare-reimbursed services to facilities they own. See H.R. 5198, 100th Cong., 2d Sess., 134 CONG. REC. H6791 (daily ed. Aug. 10,

cently adopted federal statutory prohibition of efficiency incentive plans is aimed at "direct and indirect" payments.²³³ If a physician treats some of the patients from whom the bonus derives, the physician is profiting (at least indirectly) by reducing or eliminating services. This is true despite the laundering of the bonus payments through a group organization and the dilution of the incentive through apportionment formulae.

E. *Evaluation of Fee-splitting Policy*

Fee splitting statutes cripple the institution's ability to respond to cost containment pressures with innovative strategies for motivating physician efficiency. This disability arises from two opposing consequences wrought by efficiency incentive payments: (1) the primary effect of promoting the reduction of services and (2) the secondary effect of promoting referrals. Each side of the fee splitting coin needs to be addressed now from a policy perspective.

1. The Rationale for Referral Fee Prohibitions

Classic fee splitting prohibitions attack referral fees. These prohibitions are intended to suppress inducements for ordering unnecessary care and to eliminate influences on the choice of a source of care.²³⁴ These incentives are ubiquitous in traditional medical practice. "Practicing physicians now have financial interests in diagnostic laboratories, radiologic imaging centers, walk-in clinics, ambulatory surgery centers, dialysis units, physical therapy centers, and other such facilities. In most of these business ventures, the investing physicians' profits depend, at least in part, on referral of patients to these facilities . . ."²³⁵ Moreover, the fee-for-service payment method itself creates an

1988).

²³³ See 42 U.S.C.A. §1320a-7a(b) (West Supp. 1988); see also *supra* notes 207-09 and accompanying text (discussing federal statute). Some have argued that this statute permits group incentive arrangements. The House Report explains that allowing physicians to "share in an overall operating surplus" presents no threat to quality of care because "there is no *direct link* between [an individual] physician's treatment decision and the amount of any bonus received." H. R. REP. NO. 727, *supra* note 210, at 444, reprinted in 1986 U.S. CODE CONG. & ADMIN. NEWS at 3841 (emphasis added). At least one prominent health care attorney has concluded that this "direct link" is critical to Congress' thinking. See Dechene, *supra* note 210, at 8-9. If so, this thinking did not survive the drafting process.

²³⁴ Cf. Adams & Klein, *supra* note 218, at 19 (discussing Medicare Anti-Fraud and Abuse Law).

²³⁵ Relman, *Dealing With Conflicts of Interest*, 313 NEW ENG. J. MED. 749, 749 (1985); cf. Egdahl & Taft, *supra* note 192, at 61 ("The U.S. health care system has become deeply entrepreneurial, with financial incentives incorporated at many levels.").

inherent incentive to order self-referrals.²³⁶ Physicians who are influenced by a kickback to order unnecessary services or to choose referred care contrary to a patient's best interests would also be influenced by the fees they directly receive to perform inappropriate procedures themselves.

Given the pervasiveness of self-referral incentives, it is difficult to understand why incentives for referrals to other doctors are so stigmatized. A rule of necessity provides the best justification for distinguishing traditional treatment incentives from referral fees.²³⁷ When the incentive is secondary to a beneficial purpose, as in the fee-for-service form of payment, it can be tolerated. When it is a naked payment, no social benefit justifies tolerance. We reluctantly accept the inflationary incentives of the fee-for-service system because they ensure physician fidelity to patients' interests. Naked referral fees have no such saving grace.²³⁸

Ultimately, however, this justification is unsatisfactory. First, under this rationale, the statutes are overbroad. They are not restricted, facially or as interpreted, to naked or unnecessary referral fees.²³⁹ Second, even naked referral fees can perform a beneficial function. Medical economist Mark Pauly contends that referral fees counteract a general practitioner's temptation not to refer patients to specialists, and they induce the referring physician to search out the most efficient provider—the physician who can afford to pay the most.²⁴⁰

²³⁶ Cf. Adams & Klein, *supra* note 218, at 21 ("[T]his incentive exists in every instance where a provider or supplier administers any healthcare service . . .").

²³⁷ Another justification is the secrecy that tends to characterize referral fees. Referral fees are often labelled kickbacks because, when disguised as compensation for services that are not actually needed such as "processing" and "interpreting" lab test results, they introduce a fraudulent or deceptive element. By contrast, the incentives inherent in traditional medical practice "are clearly visible to all concerned. . . . When patients have any doubts, they are free to seek other advice." Relman, *supra* note 235, at 750.

These secrecy concerns do not justify outright prohibition of all forms of fee splitting, particularly when the prohibition is enforced with the severity of felony punishment. Secrecy can be resolved by disclosing the conflict of interest; several states require disclosure from physicians who refer patients to institutions they own. See CAL BUS. & PROF. CODE § 654.2 (West Supp. 1988); WASH. REV. CODE ANN. § 19.68.010 (1978). Criminalization of referral fees aggravates rather than solves the secrecy concern by creating the need to disguise the source or purpose of incentive fees.

²³⁸ See Relman, *supra* note 4, at 99.

²³⁹ See *supra* notes 203-09, 216-19 and accompanying text.

²⁴⁰ See Pauly, *The Ethics and Economics of Kickbacks and Fee Splitting*, 10 BELL J. ECON. 344, 347 (1979). This economic analysis of referral fees is particularly relevant to DRG incentive plans, given the prospective payment system's purpose of promoting market-like incentives. Hospitals that perform best under the DRG system will be able to pay their physicians the highest rewards, thereby directing patients to the more economical hospital. In the long run the government will benefit as well be-

The third troubling aspect of the "necessary evil" justification for allowing only traditional payment methods to escape referral fee scrutiny is that the medical profession elevates fee-for-service reimbursement to a virtue. Doctors view it as the ethical glue that binds them to their patients' interests; they vigorously attack any attempt to loosen that bind. But referral fees also encourage physicians to seek out beneficial forms of treatment. Thus, an element of hypocrisy exists in the profession's "unanimous, vitriolic condemnation of fee splitting" as unethically interfering with the physician's allegiance to the patient.²⁴¹ The hypocrisy is heightened when the profession seizes on fee splitting statutes to attack the very arrangements that attempt to correct the necessary evils inherent in traditional reimbursement.²⁴² It is as if the patient racked with chronic pain were suddenly to become fastidious about the prick of the needle that injects the morphine.

2. The Rationale for Prohibiting Antireferral Fees

The federal prohibition of hospital incentive plans evinces hypocrisy of a different sort. Congress' perverse use of the referral fee concept to strike at antireferral fees flies directly in the face of its own cost-containment reimbursement policy.²⁴³ It is difficult to imagine more precipitous and poorly conceived legislation. Federal policymakers are operating under the misconception that we can save money without sacrificing either the quality or the quantity of medical services delivered.

cause overall treatment costs will be lower when it recalculates the average hospital costs on which prospective payments are based.

²⁴¹ See Veatch, *Ethical Dilemmas of For-Profit Enterprise in Health Care*, in *THE NEW HEALTH CARE FOR PROFIT*, *supra* note 54, at 130.

²⁴² The same point can be made concerning the state disclosure requirements imposed on physicians who refer patients to institutions they own. See CAL BUS. & PROF. CODE § 654.2 (West Supp. 1988); WASH. REV. CODE ANN. § 19.68.010 (West 1978). These restrictions are sensible in the traditional fee-for-service system where rendering more services leads to collecting more fees. Under the prospective payment system, however, it is counterproductive to discourage self-referrals because payment incentives reach physicians only if the physician is brought within the economics of the institution. Discouraging self-referrals therefore dampens the system's effects by insulating physicians from the incentives inherent in their own medical enterprises.

Nonetheless, statutes rarely prohibit self-referrals outright. See *supra* note 232. The more common disclosure requirements do not substantially deter the functioning of such arrangements and they preserve the patient's interest in full awareness of the incentives that affect physicians' decisions. Therefore, disclosure requirements work an acceptable compromise between the need for organizational innovation and the need to protect patient autonomy.

²⁴³ Another paradoxical aspect of the statute is that it prohibits only *positive* financial incentives. See 42 U.S.C. § 1320a-7a(b) (Supp. IV 1986) (prohibiting in part "payments . . . to reduce or limit services" (emphasis added)). It does not reach *penalties* for excessive services, even though this complementary form of financial inducement may have a stronger effect.

Congress' action originated from the outrage with which the medical profession greeted both the Paracelsus Hospital DRG incentive plan and the reports that a number of other hospitals were contemplating similar action.²⁴⁴ Prodded by these complaints, the General Accounting Office issued an influential report that formed the basis for the legislation.²⁴⁵ The tone of the report is reflected in its title, *Physician Incentive Payments by Hospitals Could Lead to Abuse*. The GAO concluded that "the possibility exists that physician incentive plans provided by hospitals may give physicians too strong an incentive to . . . reduce to unacceptable levels the amount of care provided."²⁴⁶ Thus, Congress acted on entirely speculative and inchoate concerns. Not a shred of evidence existed that such plans actually lead to systemic abuse.²⁴⁷

Absent such documentation, the congressional response was overbroad and heavyhanded.²⁴⁸ HMOs were allowed a reasonable degree of

²⁴⁴ See AMA Judicial Council, *Reports of the Judicial Council of the American Medical Association*, 253 J. A.M.A. 2424, 2425 (1985) (expressing disapproval of legislation that allows physician remuneration based in part on hospital profitability); Comment, *Medicare-Medicaid Anti-Fraud*, *supra* note 216, at 733 (discussing AMA objections to the Paracelsus plan); Brinkley, *Plan for Cutting Hospital Costs by Rewarding Doctors Draws AMA Fire*, N.Y. Times, Sept. 24, 1985, at A24, col.1, A25, col. 1 (discussing the investigation of the Paracelsus arrangement and the possibility of such arrangements leading to corruption).

²⁴⁵ See SENATE COMM. ON FINANCE, MEDICARE AND MEDICAID PATIENT AND PROGRAM PROTECTION ACT OF 1986, S. REP. NO. 520, 99th Cong., 2d Sess. 26 (1986) [hereinafter S. REP. NO. 520].

²⁴⁶ GAO REPORT, *supra* note 194, at 22 (emphasis added).

²⁴⁷ In fact, the GAO conceded that no one has "identified any quality of care problems that could be traced to the incentive plan at Paracelsus hospitals." *Id.* at 16; see also FOR-PROFIT ENTERPRISES IN HEALTH CARE, *supra* note 34, at 162 ("[T]here is a paucity of data on the effects of these arrangements on medical decision making . . ."). The government has continued this reactionary response in its recent study of HMO incentive plans. The GAO has suggested that Congress "retain a ban on arrangements that closely link financial rewards with individual treatment decisions," despite acknowledging that it "could not identify any studies relating HMO physician incentives to the quality of care provided Medicare patients." GAO, PHYSICIAN INCENTIVE PLANS, *supra* note 192, at 3, 5.

²⁴⁸ It might be argued that Congress has not expressed its final opinion because it only intended to prevent these new arrangements while they were being studied. This is not an accurate reading of the legislation, however, which calls for further study of only HMO incentive plans. See Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, § 9313(c)(3), 100 Stat. 1874, 2003 (contained at 42 U.S.C. § 1320a-7 note (Supp. IV 1986)).

It is interesting to note that the same concerns Congress and the AMA expressed about hospital incentive plans were used to attack HMOs during the early 1970s when that new form of reimbursement started to become widespread, see Geist, *Incentive Bonuses in Prepayment Plans*, 291 NEW ENG. J. MED. 1306, 1308 (1974) ("The medical profession should lead in the attempt to amend federal and state laws so that payment of incentive-bonus rewards to physicians would be outlawed in prepayment plans . . ."), but HMO incentive plans have not led to systematic abuse after 15

flexibility for productive experimentation during the developmental stage of their industry. They demonstrated that modest efficiency bonuses designed to counteract fee-for-service incentives are acceptable even if directed at individual physicians. Despite this encouraging evidence, Congress squeamishly compromised at the outset the fundamental reimbursement reform recently introduced by the Medicare program. Hospital efficiency incentive plans, like HMO plans,²⁴⁹ strive to temper fee-for-service abuses by experimenting with the appropriate mix of quality and economy incentives during the formative period of prospective payment. In stifling this initiative, Congress was driven by a single-minded focus on weeding out any potential for lowering the quality of care. This bludgeoning of physician incentive plans entirely loses sight of Congress' established reimbursement policy that allows hospitals to profit based on their ability to reduce services. The insights of Professors Havighurst and Blumstein, who convincingly explained the inevitable tendency of quality concerns to undermine governmental cost containment programs, have been proven correct once again: "A policy . . . in which a taboo surrounds any concession to the reality of limited resources is bound to be rich in posturing and assertion" and impoverished in effect.²⁵⁰

Any reimbursement policy will have the potential to induce some form of abusive behavior. Traditional fee-for-service reimbursement suffers from the costs of overutilization, the harms of unnecessary treat-

years of experience even though such plans also reward physicians in direct proportion to the services they limit. See P. FELDSTEIN, *HEALTH CARE ECONOMICS* 339-43 (2d ed. 1983) (presenting evidence on the performance of HMOs). Indeed, these incentive arrangements are viewed as vital to the HMO mode of operation, which is why the legislation does not apply to HMOs until the Secretary of Health and Human Services has conducted further study. See Pub. L. No. 99-509, § 9313(c)(3), 100 Stat. 1874, 2003 (contained in 42 U.S.C. § 1320a-7 note (Supp. IV 1986)); see also S. REP. NO. 520, *supra* note 245, at 26 ("Incentive arrangements of this type [HMO] . . . have been found to provide appropriate incentives for the delivery of cost-effective health care services."); H.R. REP. NO. 727, *supra* note 210, at 444, *reprinted in* 1986 U.S. CODE CONG. & ADMIN. NEWS at 3841 (recognizing "that incentive arrangements are necessary to the operation of some types of HMOs . . . [and] that many of these arrangements pose no inherent threat to quality of care"). Indeed, given the congressional view of HMOs, it is highly unlikely that an absolute incentive prohibition will ever take effect for HMOs. Because efficiency incentive plans "go to the heart of how HMOs operate," a complete ban would destroy or radically alter the industry. Traska, *Managed Care, HOSPITALS*, May 5, 1987, at 52, 55.

²⁴⁹ A possible basis for distinguishing HMOs from hospitals is that HMO patients are more aware of an HMO's emphasis on cost containment. See Stromberg, *Physician Incentive Plans*, *HEALTH SPAN*, Aug.-Sept. 1986, at 2, 2. There is less disparity, however, between hospitals and IPAs, the HMO type in which individual physician incentive plans are most prevalent. See *id.* In any event, this argument justifies only a disclosure requirement.

²⁵⁰ Havighurst & Blumstein, *supra* note 44, at 7.

ment, and the distortions of rewarding self-referrals. We trust professional ethics to hold these inflationary incentives in check, but ethics, coupled with peer pressure, the threat of malpractice liability, and competitive business forces, serve even more strongly to constrain health care providers from responding to deflationary pressures with excessive cuts in quality.²⁵¹

These constraints will not necessarily work perfectly, but they do create some margin for error so that a rigidly prophylactic attitude such as that exhibited by Congress is not warranted. The extent to which these constraints will be effective is a question for empirical verification after a period of trial, and perhaps error. Even if oversight of incentive plans is ultimately required, the fee splitting concept is an extremely blunt and inexact tool for hammering out the fine ethical and policy distinctions required in this field.²⁵²

In sum, the government failed to see clearly through the medical profession's vitriolic barrage to the observation made recently by the prestigious Institute of Medicine: "All compensation systems[] . . . present some undesirable incentives for providing too many services, or too few. No system will work without some degree of integrity, decency, and ethical commitment on the part of professionals. Inevitably, we must presume some underlying professionalism that will constrain the operation of unadulterated self-interest."²⁵³ Ironically, doctors were successful in convincing Congress that they lack this "professionalism" sufficient to "constrain the operation of unadulterated self interest."²⁵⁴

3. Fee Splitting and Physician Autonomy

The disingenuous nature of the medical profession's argument that doctors will run rampant if hospitals share some of their efficiency-generated savings suggests that the true source of its opposition lies elsewhere. The profession's real concern may be the effect these plans will have on physician autonomy. Doctors perceive that Medicare's

²⁵¹ See generally Stromberg, *supra* note 249, at 2 (discussing remedies for risks in physician incentive plans).

²⁵² See Adams & Klein, *supra* note 218, at 22 ("[B]anning all arrangements that create economic incentives . . . is simply inconsistent with our basic economic system. It is throwing out the baby with the bathwater.").

²⁵³ FOR-PROFIT ENTERPRISE IN HEALTH CARE, *supra* note 34, at 153.

²⁵⁴ *Id.* The medical profession's protests were particularly disingenuous because "[m]ost physicians . . . seem to claim that financial incentives do not influence their patient care decisions" in other contexts. Luft, *supra* note 184, at 108.

It is also curious that doctors have mounted their campaign only against hospitals, leaving HMOs free, at least for the moment. One possibility is that the profession views its independent staff positions at hospitals as much more important to its economic well-being than its salaried positions at HMOs.

payment system will lead to institutional control over their clinical decisions.²⁵⁵ Thus, preserving their professional sovereignty is likely a primary motive for attacking DRG incentive plans. It is not accidental that physicians turn to the fee splitting concept to promote this interest. Fee splitting challenges have long been used to preserve economic and professional dominance. For example, referral fee prohibitions have been used to suppress competition by inhibiting both price discounting²⁵⁶ and physician advertising.²⁵⁷ The fee splitting prohibition laws have also prevented hospitals from placing doctors in a more subservient employee-type status by paying them to join the medical staff.²⁵⁸ These applications of the concept might be viewed as isolated or abusive, but subtle forms of hegemonic aggrandizement lie at the very core of fee splitting prohibitions. The rationale for prohibiting fee splitting rests on the preservation of a one-to-one relationship between services and payment (more graphically expressed as "you eat what you kill"). The unadulterated one-to-one relationship between work and pay preserves professional autonomy by protecting physicians from any financial influence other than that which they generate themselves. Fee-splitting laws thus embody the traditional values of solo, fee-for-service practice. The explicit statutory phrasing sometimes expressly prohibits payment for "professional services not actually and personally rendered."²⁵⁹ The one-to-one ethic is also quite explicit in the AMA House of Delegates' rationale for its condemnation of hospital incentive plans: "[P]hysicians are not entitled to derive a profit that results directly or indirectly from service delivered by other health care providers"²⁶⁰

²⁵⁵ See, e.g., Gregory, *DRGs Part 1—How the Government Requires You to Impose Life-threatening Medical Restrictions*, LEGAL ASPECTS MED. PRAC., March 1986, at 1, 2.

²⁵⁶ See, e.g., *State v. Abortion Information Agency*, 37 A.D.2d 142, 144, 330 N.Y.S.2d 927, 929 (1971) (A "discount . . . quite clearly is the equivalent of fee splitting."), *aff'd*, 30 N.Y.2d 779, 285 N.E.2d 317, 334 N.Y.S.2d 174 (1972).

²⁵⁷ Cf. *id.* at 147, 330 N.Y.S.2d at 932 (Steuer, J., dissenting) (subjecting an abortion referral service to the physician fee splitting statute discourages the nationwide advertising of the service).

²⁵⁸ See Hall, *supra* note 219, at 624. Hospitals thus must compete for doctors by providing services such as newer and more sophisticated technological equipment, discounted office space, and other amenities that enhance professional prerogative. In contrast, if hospitals could purchase medical staff membership, physicians would be reduced to a more subservient employee-type status. Having bought out its physicians, the hospital might then demand exclusivity and impose more bureaucratic control.

²⁵⁹ KY. REV. STAT. ANN. § 311.595(18) (Michie/Bobbs-Merrill 1983); see also WIS. STAT. ANN. § 448.08(1) (West 1988) ("[N]o person licensed . . . under this chapter may give or receive . . . any fee . . . for any professional services not actually rendered personally . . .").

²⁶⁰ AMA Judicial Council, *supra* note 244, at 2425.

This professional autonomy ethic plays itself out in both halves of the fee-splitting concept. The core rationale for prohibiting referral fees is to sanitize a physician's referral decision from any financial influence. The law leaves unaffected a physician's financial stake in nonreferrals. Evident from this selective prohibition of only incentives to refer patients to other doctors is a preservation of individual physician autonomy. Prohibiting antireferral fees is intended even more directly to prevent financial constraints on medical judgment, the very constraints that are designed to counteract the self-referral incentives of traditional reimbursement.

The professional autonomy motive for opposing efficiency incentives is short-sighted. Under prospective payment, hospitals must find some method to control physician behavior. The alternatives to financial inducement are even more threatening to physician autonomy. Because financial incentives are directed at the individual physician and do not attempt to control the specifics of clinical decisionmaking, ultimately these incentives may be the technique that is most consistent with professional values.

IV. ORGANIZATIONAL REFORM OF MEDICAL INSTITUTIONS

In contrast with the narrowly tailored control devices previously discussed such as financial incentive plans and treatment directives, organizational reforms might hold more promise for bridging the chasm between institutional and physician interests.²⁶¹ The internal structure

²⁶¹ A rapidly growing body of literature explores a variety of prospects for hospital reorganization. See, e.g., FOR PROFIT ENTERPRISE IN HEALTH CARE, *supra* note 34, at 171-81 (noting the growth of large multi-institutional systems and the increased administrative power over professionals); M. ROEMER & J. FRIEDMAN, *supra* note 30, at 277-82, 298-99 (noting that current trends point toward a gradual tightening of all internal hospital administrative procedures); Burchell, White, Smith & Piland, *Physicians and the Organizational Evolution of Medicine*, 260 J. A.M.A. 826, 826-27 (1988) (surveying literature on organizational change); Goss, *Patterns of Bureaucracy Among Hospital Staff Physicians*, in THE HOSPITAL IN MODERN SOCIETY 170 (E. Freidson, ed. 1963) (discussing the influence of physicians' professional norms and values at the organizational level); Madison & Konrad, *Large Medical Group-practice Organizations and Employed Physicians: A Relationship in Transition*, 66 MILBANK Q. 240, 277 (arguing that "a real loss of traditional physician autonomy is occurring and that medicine as a profession is moving toward the same corporate context in which other professions, such as law and accounting, now operate"); Scott, *supra* note 72, at 213-14 (discussing the structural features, advantages, and disadvantages, of the autonomous, heteronomous, and conjoint models of professional organizations); Shortell, Morrissey & Conrad, *Economic Regulation and Hospital Behavior: The Effects on Medical Staff Organization and Hospital-Physician Relationships*, 20 HEALTH SERVICES RES. 596, 598-99 (1985) (examining changes in medical staff organization and hospital-physician relationships); Shortell, *The Medical Staff of the Future: Replanting the Garden*, FRONTIERS OF HEALTH SERVICE MGMT., Feb. 1985, at

of an organization has a systemic and multidimensional effect across the spectrum of management control techniques.²⁶² Structural innovation, therefore, provides a rich vein to tap in our search for effective cost containment strategies.

A. *The Need for Hospital Reorganization*

The hospital industry, marked by a much greater degree of uniformity than other sectors of the economy,²⁶³ is particularly ripe for organizational innovation. It is dominated by the classic private sector model of a lay-controlled hospital board juxtaposed with an independent, self-governing medical staff. There is a critical need to integrate these two groups in order to bring physicians within the institution's economic framework. A survey of basic organization theory helps to understand why this is so.²⁶⁴

Unlike most organizations structured on bureaucratic, hierarchical lines of authority, the hospital is composed of several independent lines of authority—physicians, administrators, and owners—that lead to its graphic characterization as a “three-legged monster without a head.”²⁶⁵

3, 44 (discussing the major forces influencing future relationships between administrators and physicians) [hereinafter Shortell, *Replanting the Garden*]; Shortell, *supra* note 223, at 73 (concluding that a shift toward more shared models of decisionmaking will become increasingly prevalent although not dominant); Sloan & Becker, *Internal Organization of Hospitals and Hospital Costs*, 18 INQUIRY 224, 224 (1981) (questioning whether key organizational variables affect costs and are worthy of consideration when analyzing hospital cost containment).

²⁶² This is persuasively documented by comparing the performance of two basic organizational forms of HMOs, group HMOs and IPAs. IPAs, in contrast to group HMOs, are no more economical than fee-for-service practice. See F. WOLINSKY & W. MARDER, *THE ORGANIZATION OF MEDICAL PRACTICE AND THE PRACTICE OF MEDICINE* 144 (1985); Long, *supra* note 192, at 126; Redisch, *supra* note 155, at 227-30; Sorenson, Saward & Wersinger, *The Demise of an Individual Practice Association: A Case Study of Health Watch*, 17 INQUIRY 244, 249 (1980). A number of organizational factors explain why IPAs have failed to perform as efficiently as group HMOs. Group HMOs are more cohesive because they contain fewer doctors and the doctors practice in the same office, thus enhancing peer influence. The physicians' salaried compensation removes fee-for-service distortions and their employment subjects them to more direct administrative oversight and control.

²⁶³ See, e.g., M. ROEMER & J. FRIEDMAN, *supra* note 30, at 33-39 (noting the standardization movement that has characterized the hospital industry in the 20th century).

²⁶⁴ Organizational theorists have produced a stimulating body of literature attempting to formulate a coherent model of the internal structure of hospitals that predicts and explains traditional hospital behavior. See, e.g., Jacobs, *A Survey of Economic Models of Hospitals*, 11 INQUIRY 83, 83-84 (1974) (dividing theorists between those who favor “organism models” and those who favor “exchange models”); Saltman & Young, *supra* note 3, at 396-403 (using Crozier's political theory of “conflictive equilibrium” to analyze the power relationship between physicians and administrators).

²⁶⁵ See Smith, *Two Lines of Authority Are One Too Many*, MOD. HOSP., Mar.

Consequently, one must use nonhierarchical models for institutional control to understand the functioning of hospitals. The most successful is an "exchange" or "equilibrium" model, in which the hospital's various authority centers compete for control of separate domains of activity within the organization.²⁶⁶ While there are various accounts of where the equilibrium settles among the competing groups,²⁶⁷ theorists agree that physicians exercise unfettered control over all medical matters.²⁶⁸ As economist Jeffrey Harris developed in his seminal article,²⁶⁹ a hospital is, in essence, composed of two separate firms: (1) the medical staff, which controls the treatment demand function, and (2) the hospital administration, which controls the facility supply function. Historically, the supply side of hospitals has been completely responsive to the demand side, providing whatever support and equipment physicians desire. Thus, "the hospital's dual line of authority may be seen as a 'structural mechanism for assuring that managerial-economic criteria of efficiency remain[] subordinate to clinical criteria of efficiency in patient care.'"²⁷⁰

One would expect the resulting lack of integration in function, utility, and authority to undermine the institution. In the past, it has not because the interests of doctors and hospitals traditionally have been directed along parallel, if not congruent, paths. Under fee-for-service or cost-based reimbursement, they each benefitted from increased produc-

1955, at 59, 60; B. TEMPLE, E. LENTZ & R. WILSON, *THE GIVE AND TAKE IN HOSPITALS* 37, 83 (1956) (noting the conflicting interests of trustees, administrators, and physicians within the hospital organization).

²⁶⁶ See Jacobs, *supra* note 264, at 83-84, 96. In symmetrical counterpoint to economic theories of political behavior, organization science is thus developing political theories of economic behavior to help understand the functioning of complex institutions such as hospitals. See Saltman & Young, *supra* note 3, at 398.

²⁶⁷ Many theorists point to physicians as the controlling group. See, e.g., Pauly & Redisch, *The Not-for-Profit Hospital as a Physicians' Cooperative*, 63 AM. ECON. REV. 87, 87-90 (1973) (focusing on physicians' de facto control of hospitals); see also P. FELDSTEIN, *HEALTH CARE ECONOMICS* 219-23 (2d ed. 1983) (explaining the physician-control model of hospital organization theory); Saltman & Young, *supra* note 3, at 398, 404-05 (analyzing theories which contend that physicians control both medical and financial decisions within the hospital). Others see greater administration/director power, particularly over fiscal matters. See, e.g., Lee, *A Conspicuous Production Theory of Hospital Behavior*, S. ECON. J. 38, 48-58 (1971), quoted in Saltman & Young, *supra* note 3, at 398 (focusing upon administrator's control over the personal financial interests of the members of the hospital community).

²⁶⁸ See Jacobs, *supra* note 264, at 83; Saltman & Young, *supra* note 3, at 407-08.

²⁶⁹ Harris, *supra* note 47, at 467.

²⁷⁰ Begun, *Managing with Professionals in a Changing Health Care Environment*, 42 MED. CARE REV. 3, 9 (1985) (quoting Goss, Battistella, Colombotos, Friedson & Riedel, *Social Organization and Control in Medical Work: A Call for Research*, MED. CARE SUPP., May, 1977, at 1, 4). This schismatic structure is reflected in the strict division in billing for physician services separately from hospital services that persists throughout all forms of public and private reimbursement.

tion.²⁷¹ Thus, until now, growth of the facility has been the salve for potential hospital/physician conflict. Prospective payment, however, transforms this relationship into a potentially explosive one. Doctors and hospitals now face diametrically opposed incentives: doctors continue under open-ended reimbursement, while hospitals are subject to fiscal restraint.²⁷² Disappearance of the fee-for-service reimbursement that has accommodated the anomalies of hospital organization requires a dramatic²⁷³ realignment of the existing power equilibrium. The profession's grip on the internal organization of hospitals must be broken in order for cost containment to succeed.

B. *Physician Employment and the Corporate Practice of Medicine*

1. The Advantages of Physician Employment

The most obvious organizational alternative to the traditional independence of doctors is for medical institutions to restrict physician membership to a small core of doctors who practice exclusively at the institution, either as employees or independent contractors. Under both arrangements, doctors would be closely integrated into the hierarchical structure of the firm. Physician employment (or its organizational equivalent) potentially activates a number of controlling forces,²⁷⁴ many

²⁷¹ Doctors desire state-of-the-art technology, ample support services, and comfortable accommodations. It is in the hospital's interest to please doctors because physician satisfaction leads to an increased number of patients (customers). Enhanced facilities do not go unused because physicians are in a position, encouraged by hospital management, to find new uses for expanded capacity. Cf. P. FELDSTEIN, *supra* note 267, at 220-21 (noting that physicians sustain increases in hospital capacity, investment, and support services).

²⁷² See *id.* In other words, the traditional hospital structure contains a sharp division in perspective. Hospital administration is concerned with macro allocation issues of the costs of supplying medical care while, on the demand side, physicians are concerned with micro allocation issues of individual patient needs. Under open-ended, cost-plus reimbursement, this dimensional incongruity created no problems because what the physicians demanded, the hospital was eager to supply. Now, under closed-ended reimbursement systems, the costs of medical decisions are internalized on the supply side (the hospital) but they are not so on the demand side (the doctor).

²⁷³ One proposal that has received the endorsement of the three dominant health care associations (the AMA, AHA, and JCAH) is to increase physician participation in hospital decisionmaking by integrating physicians into the institution's governing structure. See Alexander, Morrissey & Shortell, *Physician Participation in the Administration and Governance of System and Freestanding Hospitals: A Comparison by Type of Ownership*, in FOR-PROFIT ENTERPRISE IN HEALTH CARE, *supra* note 34, at 402. Physician governance, however, is largely a fine-tuning effort that does not appear to have potential for sparking fundamental change.

²⁷⁴ See Glandon & Morrissey, *supra* note 225, at 172 ("As an employer, a hospital has direct control and responsibility for how physicians utilize the hospital's resources when treating patients."); Omenn & Conrad, *supra* note 65, at 1316 ("Clinical guidelines for the length of stay or for the intensity of preventive, diagnostic, and therapeutic

of which do not entail direct control over clinical discretion. As group HMOs' command of physician working hours illustrates, the firm can induce more economical treatment by scheduling more patient visits into a physician's day.²⁷⁵ Exclusive arrangements with physicians enhance other management strategies, such as education, feedback, and peer review, by concentrating these efforts on fewer individuals. Furthermore, eliminating physicians' power to withdraw their practice greatly strengthens the institution's authority: physicians are much more amenable to advice and direction when they have no alternative place to treat their patients.²⁷⁶ Finally, the terms of service can be arranged in a variety of ways to induce cost consciousness.²⁷⁷

Based on this research data and organizational theory, "[m]any observers of the medical care scene have concluded that the physician's independence needs to be subordinated to organizational controls in the interests of improved quality and efficiency of medical care."²⁷⁸ In fact, the hospital industry appears to be moving strongly in this direction already.²⁷⁹ Large numbers of hospital-based specialists such as radiolo-

services are easier to enforce when hospitals have explicit contractual agreements with physicians.").

²⁷⁵ Wolinsky and his associates have demonstrated a broad connection within the HMO industry between the degree of structural integration inherent in various HMO models and the ability to control physician behavior. On Wolinsky's continuum of hierarchical models, patient visits consistently tend to shorten as the organization becomes more bureaucratic and less autonomous. See F. WOLINSKY & W. MARDER, *supra* note 262, at 41, 139. In a similar study within the hospital industry, Roemer and Friedman found that hospitals with more highly structured medical staffs tend to have fewer expenditures per patient day. See M. ROEMER & J. FRIEDMAN, *supra* note 30, at 255-57. Finally, Sloan and Becker found lower costs per patient-day and per admission at hospitals with a large number of ancillary specialists employed or under contract. See Sloan & Becker, *supra* note 261, at 236. Notably, this association did not depend on the form of compensation; it existed even under compensation arrangements such as fee for service that might produce inflationary incentives. See *id.*

²⁷⁶ See FOR-PROFIT ENTERPRISE IN HEALTH CARE, *supra* note 34, at 174 (discussing trend toward physicians being identified with a single hospital); see also D. YOUNG & R. SALTMAN, *supra* note 169, at 124 (noting the power that physicians wield owing to their power to withdraw their patients from a hospital).

²⁷⁷ The possible compensation arrangements include salary, flat fees per patient (capitation), bonuses, penalties, and percentage of profits. See *supra* notes 186-202 and accompanying text.

²⁷⁸ Scott, *supra* note 72, at 224; see also P. STARR, *supra* note 30, at 147 (finding that hospital administration in the United States is complicated by the decentralized system in which physicians, who are not hospital employees, follow their patients into hospitals and make vital decisions concerning their care).

²⁷⁹ Medicine appears to be following the "strong trend in favor of the numerical ascendancy of the salaried professions." W. KORNHAUSER, *supra* note 110, at 5. "Already almost 50 percent of all physicians are salaried; even excluding house officers, almost 40 percent of physicians work for a salary. In the absence of any kind of professional self-regulation, that percentage will continue to grow." Relman, *The Future of Medical Practice*, HEALTH AFF., Summer 1983, at 5, 18.

gists and anesthesiologists are retained under salaried or exclusive contract arrangements.²⁸⁰ It is widely predicted that this employment trend will carry over into the arena of general medical and surgical practice as well.²⁸¹

2. The Corporate Practice of Medicine Doctrine

Past predictions of the demise of physician independence have repeatedly proven wrong primarily because of the law's longstanding prohibition of the employment of physicians in the corporate practice of medicine.²⁸² This doctrine reasons that corporate employment of physicians is illegal because the acts of practicing employees are attributable

²⁸⁰ See, e.g., Morrissey, Alexander & Shortell, *Medical Staff Size, Hospital Privileges, and Compensation Arrangements: A Comparison of System Hospitals*, in FOR-PROFIT ENTERPRISE IN HEALTH CARE, *supra* note 34, at 429-30 (analyzing hospital relationships with radiologists and anesthesiologists in terms of salary, fee for service, or percent of revenue arrangements); Scott & Lammers, *Trends in Occupations in the Medical Care and Mental Health Sectors*, 42 MED. CARE REV. 37, 62 (1985) (noting that over half the active physicians in the United States as of 1980 are salaried employees). However, the form of compensation typically used for hospital-based physicians—fee for service or percentage of revenues—retains inflationary incentives. Only about 10 percent of such physicians are paid in a form, such as salary, that rewards efficiency or eliminates inflationary incentives. See *id.*

²⁸¹ See FOR-PROFIT ENTERPRISE IN HEALTH CARE, *supra* note 34, at 172 (noting an increase in employment and employment-like contracts); Johnson, *An Emerging Medical Staff Organization*, HOSP. ADMIN., Winter 1972, at 26, 83 (predicting the replacement of direct patient billing by physicians with some contractual relationship between hospital and physician, owing to increases in super-specialization and the involvement of several physicians in medical routines); Scott, *supra* note 72, at 223-24 (noting an emphasis on organizational arrangements supporting a well-defined division of labor). But see Glandon & Morrissey, *supra* note 225, at 174 ("In our judgment, the employer-employee relationship will not be used by many hospitals.").

²⁸² See, e.g., *Garcia v. Texas State Bd. of Medical Examiners*, 384 F. Supp. 434, 437-39 (W.D. Tex. 1974) (per curiam before a three-judge district court panel) (upholding such a restriction as a legitimate exercise of the police power designed to protect the vitally important doctor-patient relationship from corporate abuses), *aff'd mem.*, 421 U.S. 995 (1975); *Rockett v. Texas State Bd. of Medical Examiners*, 287 S.W.2d 190, 191-192 (Tex. Civ. App. 1956) (finding abundant support from other jurisdictions to justify the cancellation of a physician's medical license because of his employment by a non-physician); Forgotson, Roemer & Newman, *Innovations in the Organization of Health Services: Inhibiting vs. Permissive Regulation*, 1967 WASH. U.L.Q. 400, 402 (noting that "[r]ules prohibiting the corporate practice of medicine currently exist in all states except Missouri and Nebraska" (citation omitted)); Hansen, *Laws Affecting Group Health Plans*, 35 IOWA L. REV. 209, 218 n.32 (1950) (citing 21 states that subscribe to the corporate practice doctrine). A few states have codified the doctrine. See CAL. BUS. & PROF. CODE § 2400 (West Supp. 1988); COLO. REV. STAT. § 12-36-134(7) (1985); OHIO REV. CODE ANN. § 1701.03 (Anderson 1985); WIS. STAT. ANN. § 448.08 (West 1988).

Only two states have explicitly rejected the corporate practice of medicine doctrine in the context of the employment of physicians. See *Sager v. Lewin*, 128 Mo. App. 149, 155-56, 106 S.W. 581, 583 (1907); *State Electro-Medical Inst. v. State*, 74 Neb. 40, 43-49, 103 N.W. 1078, 1079 (1905).

to the corporation and only natural persons are eligible to hold a medical license.²⁸³ This puzzling doctrine is clouded with confused reasoning and is founded on an astounding series of logical fallacies.²⁸⁴ Because judicial activity in this area has slackened over the last twenty years, it is commonly believed that the corporate practice prohibition is dying a quiet death.²⁸⁵ I am not so optimistic.

The doctrine has a long history of suppressing needed innovation in times of industry upheaval. During the 1930s, when prepaid group practices (now known as HMOs) were being developed in response to severe gaps in insurance coverage, the corporate practice doctrine was a major obstacle that took decades to remove.²⁸⁶ During the 1950s, when hospitals felt an increasing need to employ hospital-based specialists in response to the technological transformation of medical care, a number of state attorney general opinions struck down their initiatives.²⁸⁷ During the 1990s, there will be tremendous pressure to search for more cost conscious organizational forms and relationships. These changes will raise combined threats of commercialization and professional subordination, concerns that will be a powerful stimulus to professional opposition.²⁸⁸ This opposition will surely invoke the corporate practice doc-

²⁸³ See, e.g., *Rockett*, 287 S.W.2d at 192.

[W]here a corporation operates a clinic or hospital, employs licensed physicians and surgeons to treat patients, and itself receives the fee, the corporation is unlawfully engaged in the practice of medicine. This is true because it has been universally held that a corporation as such lacks the qualifications necessary for a license, and without a license, its activities become illegal.

Id. (quoting *United States v. Am. Medical Ass'n*, 110 F.2d 703, 714 (D.C. Cir. 1940)).

²⁸⁴ See generally Rosoff, *The Business of Medicine: Problems with the Corporate Practice Doctrine*, 17 CUMB. L. REV. 485, 490-503 (1987); Note, *The Corporate Practice of Medicine Doctrine: An Anachronism in the Modern Health Care Industry*, 40 VAND. L. REV. 445, 475-88 (1987).

²⁸⁵ See, e.g., Roble & Mason, *supra* note 216, at 462 ("the doctrine itself appears to be in decline"); Wiorek, *The Corporate Practice of Medicine Doctrine: An Outmoded Theory in Need of Modification*, 8 J. LEGAL MED. 465, 475-84 (1987) (discussing the 27 states in which the author feels that the corporate practice doctrine is "[a]mbiguous or [h]as [b]een [s]ignificantly [e]roded or [n]eglected"); Note, *supra* note 284, at 470 & n.185 ("[I]n recent years corporate practice prohibitions generally have been ignored.").

²⁸⁶ For a discussion of cases, see Hansen, *Group Health Plans: A Twenty-Year Legal Review*, 42 MINN. L. REV. 527, 534-36 (1958); Hansen, *supra* note 282, at 211-19; Laufer, *Ethical and Legal Restrictions on Contract and Corporate Practice of Medicine*, 6 LAW & CONTEMP. PROBS. 516, 525-27 (1939); Special Project, *The Role of Prepaid Group Practice in Relieving the Medical Care Crisis*, 84 HARV. L. REV. 887, 960-62 (1971); Note, *Right of Corporation to Practice Medicine*, 48 YALE L.J. 346, 347-49 (1938).

²⁸⁷ See Willcox, *Hospitals and the Corporate Practice of Medicine*, 45 CORNELL L.Q. 432, 477 & n.137 (1960) (citing [1953-1954] Colo. Rep. Att'y Gen. 84; Ohio Ops. Att'y Gen. 750 (1952); [1954-1955] Va. Ops. Att'y Gen. Ops. 146).

²⁸⁸ See Veatch, *supra* note 241, at 134-36.

trine to preserve independence from the institution.²⁸⁹ Over a half century ago, a prophetic commentator warned that the doctrine stood in the way of "extensive experimentation with methods of medical organization" stimulated by "[e]fforts to obtain adequate medical care at reasonable costs."²⁹⁰ Yet courts were entirely unresponsive in tempering the doctrine. Little more can be expected in today's climate of change and experimentation. Therefore, as fair warning for the next decade and beyond, this Article will attempt to explain the mystery of the doctrine's survival throughout the 20th century and its adverse impact on current organizational relationships.

a. *Corporate Practice as Unlicensed Practice*

The only satisfactory way to make sense of the corporate practice doctrine is to recognize that it is composed of two entirely distinct branches, one whose foundation is statutory and the other common law. As a statutory doctrine, it merely applies ordinary respondeat superior principles to a violation of the medical practice act by holding a corporation responsible for the acts of unauthorized practice committed by its agents.²⁹¹ A corporation whose lay administrators control the treatment decisions of its doctors is engaged in unlicensed practice. But this is not because of the employment of doctors simpliciter or the mere potential for lay influence. The statutory-based doctrine should apply only when the actual conduct of lay employees constitutes the practice of medicine,²⁹² and its only effect should be to extend responsibility for the

²⁸⁹ Instances in which the doctrine has been recently invoked are documented in Rosoff, *supra* note 284, at 497-99; Note, *supra* note 284, at 471-74; *see also* United Calendar Mfg. Corp. v. Huang, 94 A.D.2d 176, 180, 463 N.Y.S.2d 497, 500 (1983) (refusing to enforce contract between corporation and previously employed doctors); Flynn Bros., Inc. v. First Medical Assocs., 715 S.W.2d 782, 785 (Tex. Ct. App. 1986) (sustaining challenge to management contract for hospital emergency services); Morelli v. Ehsan, 48 Wash. App. 14, 19-21, 737 P.2d 1030, 1033-34 (1987) (sustaining corporate practice challenge to a medical clinic organized as a limited partnership).

Even if the doctrine exists only nominally, it will still continue to exert a powerful influence on the willingness of institutions to experiment with organizational change. *See* Welch, *HMO Enrollment: A Study of Market Forces and Regulations*, 8 J. HEALTH POL. POL'Y & L. 743, 754-55 (1984).

²⁹⁰ Note, *supra* note 286, at 346; *see also* Laufer, *supra* note 286, at 516 ("In response to profound social, economic and technological changes experimentation with new forms of medical practice has begun on a nationwide basis." (footnote omitted)); *id.* at 527 ("As the new forms of practice spread, . . . the [doctrine's] sweep becomes oppressive . . . as it threatens desirable experimentation.").

²⁹¹ *See* Davies, Freyfogle & Richardson, *Unlawful Practice of Medicine by Health Care Entities*, 27 RES GESTAE 132, 132 (1983); Laufer, *supra* note 286, at 525-26; Willcox, *supra* note 287, at 444-45, 470-76; Special Project, *supra* note 286, at 960-61; Note, *supra* note 286, at 348.

²⁹² *See, e.g.*, Blank v. Palo Alto-Stanford Hosp. Center, 234 Cal. App. 2d 377,

employees' illegal actions to the corporate entity. It is irrelevant that a corporation is ineligible for a medical license. The licensure status of the corporation's employees determines the legality of its undertakings.

Instead of proceeding in this straightforward fashion, however, courts have given the doctrine substantive scope that entirely loses sight of the limited respondeat superior focus of its statutory origins. In doing so, courts engage in an astonishing series of fallacies. A blatant example of this faulty reasoning is the illogical way it attributes human characteristics to a corporation. I call this the anthropomorphic fallacy.

Courts usually phrase the corporate practice argument in the following fashion: Corporations cannot possibly qualify for a medical license because the applicant must demonstrate moral character and professional competence. Corporations, of course, do not have a moral character, cannot attend medical school, and cannot be tested.²⁹³ This argument addresses only half of the issue, however. If the moral character and exam taking activities of corporate employees cannot be attributed to the corporate entity, then logically corporations cannot engage in the physical acts of medical practice as well. Conversely, if employees' practice activities are attributable to the corporation, the licensure qualifications and status of those who perform the activity must also be attributable to it.²⁹⁴ The corporate practice doctrine totally con-

390, 44 Cal. Rptr. 572, 580 (1965) (rejecting the corporate practice charge because "it appears that the doctors retain their freedom of action"); *cf.* *Hyde v. Jefferson Parish Hosp. Dist. No. 2*, 513 F. Supp. 532, 540, 546 (E.D. La. 1981) (rejecting an unauthorized practice challenge to a hospital's exclusive arrangement with a group of anesthesiologists because "the hospital did not improperly engage in the diagnosis and treatment of patients"), *rev'd on other grounds*, 686 F.2d 286 (5th Cir. 1982), *rev'd on other grounds*, 466 U.S. 2 (1983).

²⁹³ See *Dr. Allison, Dentist, Inc. v. Allison*, 360 Ill. 638, 641-42, 196 N.E. 799, 800 (1935). There, the court noted,

[Medical practice] can be done only by a duly qualified human being, and to qualify something more than mere knowledge or skill is essential. The qualifications include personal characteristics such as honesty, guided by an upright conscience and a sense of loyalty to clients or patients These requirements are spoken of generically as that good moral character which is a prerequisite to the licensing of any professional man. No corporation can qualify. It can have neither honesty nor conscience

Id.

²⁹⁴ Considering the identical arguments in a different licensing context exposes the absurdity of the corporate practice doctrine:

1. The actions of drivers hired by a corporation are attributed to the corporation.
2. An eye sight examination is required for a driver's license.
3. Corporations cannot take an eye exam.
4. Therefore, a corporation that hires drivers is guilty of driving without a license.

See *Sloan v. Metropolitan Health Council of Indianapolis, Inc.*, 516 N.E.2d 1104,

founds this attribution question, however, by holding one way for the status of licensure and the other for the physical acts of practice.²⁹⁵ The best demonstration of this absurdity is that, if this anthropomorphic logic were followed consistently in all licensure contexts, hospitals could not hire nurses, barber shops could not hire barbers, and architecture firms could not hire architects.²⁹⁶

Even more astounding than the continued judicial acceptance of this flawed reasoning is that the unqualified condemnation of the corporate practice of medicine flies in the face of numerous orthodox forms of corporate practice that are central to our health care delivery system. Under the doctrine, (1) teaching hospitals and prestigious research institutions could not hire practicing medical academics and scientists; (2) federal veterans or Indian hospitals, state mental hospitals, and municipi-

1108 (Ind. Ct. App. 1987) ("It is . . . a non sequitur to conclude that because a hospital cannot practice medicine . . . , it cannot be liable for the actions of its employed agents and servants who may be so licensed. Similar logic would dictate that a city cannot be liable for the negligence of its employees in driving automobiles since the city cannot hold a driver's license . . .").

²⁹⁵ The theory of statutory illegality states that the medical practice act prohibits any person from engaging in the unlicensed practice of medicine but allows only natural persons to obtain a license. This argument gives two different meanings to the word person in a tightly knit statutory scheme. The term "person" in the disabling portion of the act includes corporations, but it excludes corporations in the enabling portion of the act. *See, e.g.,* *People v. John H. Woodbury Dermatological Inst.*, 192 N.Y. 454, 456-57, 85 N.E. 697, 698-99 (1908) (the word "person" includes any corporation not authorized to practice medicine). *But see* *Bartron v. Codington County*, 68 S.D. 309, 320, 2 N.W.2d 337, 342 (1942) (corporation not within the meaning of the term "person" in statute prohibiting the practice of medicine without a license). *See generally* Willcox, *supra* note 287, at 437-41 (analyzing the confusion surrounding the various interpretations of "person").

²⁹⁶ Hospital malpractice cases also flatly refute the corporate practice theory. The doctrine's analytical foundation is that the medical acts of employed physicians are attributable to the corporation; its policy foundation is that the employment of physicians subjects them to the control of lay owners and administrators. Hospital liability cases, however, have stated that a hospital is "powerless, under the law, to command or forbid any act by [physicians] in the practice of their profession." *Rosane v. Senger*, 112 Colo. 363, 366, 149 P.2d 372, 374 (1944); *see, e.g.,* *Brown v. St. Vincent's Hosp.*, 222 A.D. 402, 403, 226 N.Y.S. 317, 320 (1928) (A hospital "does not contract to heal or attempt to heal a patient through the agency of others."); *Adamski v. Tacoma Gen. Hosp.*, 20 Wash. App. 98, 107, 579 P.2d 970, 975 (1978) ("[T]he governing body of a hospital never actually exercises, nor can it exercise, much control over a physician's medical decisions and his actual treatment of patients, even when he is clearly an employee of the hospital . . ."). The early cases reason that the negligence of employed physicians is not attributed to hospitals because hospitals exercise no control over physicians' actions. Modern hospital liability cases do hold a hospital responsible for the negligence of employed physicians, *see* *Bing v. Thunig*, 2 N.Y.2d 656, 665-67, 143 N.E.2d 3, 8-9, 163 N.Y.S.2d 3, 10-12 (1957), but they do so *despite* this lack of control. *See supra* notes 266-70 and accompanying text. Thus, the logic of both lines of cases is diametrically opposed to the corporate practice theory. *See Sloan*, 516 N.E.2d at 1108-09 (finding corporate practice doctrine inapplicable to HMO in order to hold it liable for negligence of employed physician).

pal general hospitals could not employ their medical staffs; (3) hospitals could not retain hospital-based specialists (radiologists, pathologists, and anesthesiologists); (4) hospitals could not employ residents and interns; and (5) corporations could not engage "company doctors" to treat industry employees. Of course, all the above are conspicuous parts of our health care system.²⁹⁷ Therefore, despite the doctrine's broad sweep, the corporate practice prohibition has been used selectively to attack only those organizational forms that are unconventional and threatening to established practice formats.²⁹⁸

b. *Corporate Practice as Contrary to Public Policy*

Most courts, recognizing the difficulty of supporting the broad corporate practice prohibition with a formal statutory analysis, buttress the doctrine with a series of policy arguments:²⁹⁹ (1) corporate practice will subject corporate-employed physicians to lay control in the practice of their profession; (2) corporate practice tends to commercialize the profession; and (3) corporate practice divides the doctor's loyalty and thus interferes with the physician/patient relationship.³⁰⁰ However, these courts fail to recognize that these policy arguments create an entirely distinct branch of the doctrine governed by distinct principles and policies not found in any statute. Because the basis of this branch of the doctrine is wholly court-created, judges should be circumspect in its application. The absolutism that characterizes judicial management of the doctrine³⁰¹ is entirely inappropriate. The common law branch needs

²⁹⁷ See, e.g., Laufer, *supra* note 286, at 522 (noting the existence of the first and fifth practices); Willcox, *supra* note 287, at 460-65 (noting the existence of all five practices); Note, *supra* note 286, at 349 (first and fifth practices).

²⁹⁸ See, e.g., *Stuart Circle Hosp. Corp. v. Curry*, 173 Va. 136, 146, 3 S.E.2d 153, 157 (1939) (allowing a hospital corporation to practice, but only to the extent "as is customary and necessary in the proper conduct of its business"); *Cal. Op. Att'y Gen. No. 81-1004* (April 7, 1982) (refusing to allow the operation of an "industrial medical corporation" because it "is not an institution which is traditionally thought of as being within the health care delivery system as are hospitals and clinics"); Willcox, *supra* note 287, at 486 n.168 (noting the "genuine if unanalytical belief that . . . accepted practices are not illegal").

²⁹⁹ Courts rarely rest their reasoning solely on policy grounds. "[T]he rule seems to result from a blending of several lines of thought which are often so interwoven in a single opinion that it is difficult to know where one ends and another begins." Willcox, *supra* note 287, at 436.

³⁰⁰ See *id.* at 442-43; Note, *supra* note 284, at 467-70.

³⁰¹ See Willcox, *supra* note 287, at 435 (noting "more often than not, the rule has been stated as a categorical prohibition of all corporate practice, without relation to the evils exhibited by the cases at hand, with the result that a shadow has been cast over the whole of that very large area in which corporations customarily participate"); Note, *supra* note 284, at 470 & n.187 (arguing that the corporate practice doctrine threatens innovations in medical practice).

much greater case-by-case qualification and a more sensitive balancing of the competing policies relating to physician employment.³⁰² When weighing this balance, courts must be skeptical of the economic territory that the corporate practice doctrine protects and must also consider the countervailing policies that favor cost containment measures.

When courts enforce the corporate practice doctrine, they mistakenly suppose they are enforcing the legislature's *public* protection policies when in fact they are enforcing the profession's *economic* protection policies. The policies of preventing lay interference, commercialization, and divided loyalty, however important, do not underlie the medical practice act.³⁰³ Rather, the enumerated policies are based on professional ethics. Until enjoined by the Federal Trade Commission, the AMA vigilantly cited corporate practice as an ethical violation.³⁰⁴ The medical profession's driving concern was to protect solo, fee-for-service practice, the traditional format that preserves financial independence and professional autonomy.³⁰⁵ The doctrine's policies against lay control and divided loyalties protect physician independence. The policy against commercialization prevents others from participating in the profits from medical practice, and "ensure[s] that hospitals will not be able to compete with physicians."³⁰⁶

A lone exemplary instance of a more measured approach is found in N.M. Op. Att'y Gen. No. 87-39 (July 30, 1987):

In the absence of an express statutory answer to the question posed, we conclude that, unless prohibited by statute or by public policy considerations against lay control of MEDICAL judgment and lay exploitation of the practice of medicine, corporations organized and controlled by non-physicians may provide MEDICAL services to the public through employed physicians.

Id.

³⁰² The analyses that are used in testing the validity of covenants not to compete and those used in applying the rule of reason to antitrust issues serve as possible models.

³⁰³ The concerns of the medical practice act are prevention of incompetent practice and avoidance of public misrepresentation of credentials and qualifications. Both concerns are met if a corporation hires only licensed physicians. See Davies, Freyfogle & Richardson, *supra* note 291, at 132; Willcox, *supra* note 287, at 445; Note, *supra* note 286, at 348.

³⁰⁴ See *In re American Medical Ass'n*, 94 F.T.C. 701, 897, 1016 (1979) (finding that the AMA engaged in unfair trade practice by publishing and circulating a directive not to approve any contract for services "whose terms or conditions are inconsistent with the [AMA] *Principles of Medical Ethics*").

³⁰⁵ See Willcox, *supra* note 287, at 446 & n.35 ("We know of no suggestion that [lay] interference . . . has been a problem. Th[e] issues that have disturbed hospital-physician relationships are of a quite different kind. . . . [They] have centered around the professional prestige and prerogatives of the physician and his economic welfare and security . . ."); see also Scott, *supra* note 72, at 216 (arguing corporate practice prohibitions "reinforce the authority of the individual physician").

³⁰⁶ P. FELDSTEIN, *supra* note 267, at 221; see also P. STARR, *supra* note 30, at 215 (doctors oppose corporate enterprise in medicine to avoid sharing profits with third

Even assuming the former legitimacy of these policies, they now are anachronistic.³⁰⁷ Concern about commercialization is based on a belief that physicians' medical judgments should be unfettered by cost considerations. This same attitude underlies the bankrupt belief that society can support all treatment that produces any medical benefit, regardless of cost.³⁰⁸ 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. The commercialization charge is thus the most ill-considered of the corporate practice doctrine's policies.³⁰⁹ It disregards the fundamental causes of the health care spending crisis and blocks the reforms needed to produce more responsive medical organizations.

3. Corporate Practice in the Modern Context

The primary task of the corporate practice doctrine should be to hold corporations responsible for their lay employees' acts of unlicensed practice. Beyond this, there is a limited scope of operation for the dis-

parties); Note, *supra* note 284, at 476-77 (AMA's ethical restraints "restricted arrangements between physicians and non-physicians and . . . prevented the creation of more economical business structures.").

³⁰⁷ See, e.g., N.M. Op. Att'y Gen. No. 87-39 (July 30, 1987) ("Many of the earlier decisions in this area may not be germane to the health care environment today. A market demand for integrated health care delivery has emerged in recent years. . . . These market forces may redound to the benefit of consumers of health care.").

³⁰⁸ See *supra* notes 5 & 6.

³⁰⁹ The other policies supporting the prohibition of corporate practice are also logically inconsistent. The concern over interference with the physician-patient relationship, for instance, is entirely at odds with the rampant specialization that has become dominant under the modern team approach to medical treatment. A hospitalized surgery patient may be treated by a half dozen doctors in addition to her general practitioner. "The patient treated in [the modern hospital] receives care from a number of individuals of varying capacities and [is] not merely treated by a physician acting in isolation. The patient relies upon the effectiveness of this 'highly integrated system of activities'" *Elam v. College Park Hosp.*, 132 Cal. App. 3d 332, 344, 183 Cal. Rptr. 156, 163 (1982) (citation omitted) (quoting *Ybarra v. Spangard*, 25 Cal. 2d 486, 493, 154 P.2d 687, 691 (1944)). Owing to the technological advances in medical science, hospitals often restrict doctors to the practice areas in their field of expertise. Requiring referral to specialists for surgery and complications, and requiring the use of hospital-based radiologists, pathologists, and anesthesiologists interferes with the primary doctor-patient relationship to a far greater degree than simple employment. Indeed, employment may enhance a physician's attention to her patient's needs because she is relieved from the burdens of practice administration.

Moreover, the concern that an employed physician's loyalty to the patient will be diverted by the physician's concurrent loyalty to the employer is disingenuous. Physicians who practice in partnerships also have competing loyalties to their partners. Even solo practitioners have overlapping loyalties to their other patients. If physicians are able to serve two masters in these contexts, it is difficult to see any uniquely troubling concern in the employment context.

tinctly different branch of the doctrine that enforces certain public policy considerations. Like other common law doctrines used to circumscribe freedom of contract, however, the terrain is narrow and must be carefully traversed. Courts should not prohibit arrangements if there is a mere potential for abuse; they should prohibit only those arrangements that are demonstrably harmful.

Regrettably, there is no indication that the courts will begin to confine the doctrine to its proper boundaries. Courts continue to apply corporate practice prohibitions in the broadest possible terms and create only limited, ad hoc exceptions to reconcile the doctrine's reach with the realities of the conventional health care industry. For instance, courts have crafted specific exemptions to address prominent instances of physician employment by hospitals and HMOs.³¹⁰ Although these numerous special exemptions conform to established industry practices, they do not adequately confine the doctrine in a time of tremendous change and upheaval such as the present because their ad hoc nature prevents their extension to novel arrangements.³¹¹ Allowing non-profit organizations to employ doctors does not assist the for-profit organizations proliferating in today's health care environment. Allowing the employment of interns or hospital-based physicians does not protect the hospital that wants to employ its entire medical staff; nor may a hospital safely structure an independent contractor relationship with its medical staff, an innovation widely proposed in the hospital management litera-

³¹⁰ For example, some courts distinguish between employed physicians and independent contractors. See Willcox, *supra* note 287, at 453. But see *People ex rel. State Bd. of Medical Examiners v. Pacific Health Corp.*, 12 Cal. 2d 156, 159, 82 P.2d 429, 430 (1938) (stating "it is immaterial whether the appointed practitioners are termed employees, agents, or appointees of the [health corporation]"). An exception for non-profit entities is more frequently encountered, particularly in California decisions. See *Complete Serv. Bureau v. San Diego County Medical Soc'y*, 43 Cal. 2d 201, 209, 272 P.2d 497, 501 (1954); *Pacific Health Corp.*, 12 Cal. 2d at 160, 82 P.2d at 431; see also Willcox, *supra* note 287, at 459, 466 (nonprofit, philanthropic associations may employ licensed physicians to render medical services to their members); Special Project, *supra* note 286, at 961-62 (courts distinguish between profit and nonprofit plans, holding the latter valid under the corporate practice rule). Courts apply another exemption for apprenticing physicians, such as interns and residents, reasoning that this class of physicians does not have a direct relationship with their patients. See *Rush v. Akron Gen. Hosp.*, 171 N.E.2d 378, 380 (Ohio Ct. App. 1957). In New York, courts have found in hospital enabling acts implicit authority for hospital corporations to employ physicians. See *Albany Medical College v. McShane*, 66 N.Y.2d 982, 983, 489 N.E.2d 1278, 1279, 499 N.Y.S.2d 376, 377 (1985). Similarly, courts exempt HMOs based on either explicit or implicit language in their state enabling acts. See *California Physicians' Serv. v. Garrison*, 155 P.2d 885, 891-92 (Cal. Dist. Ct. App. 1945), *aff'd*, 28 Cal. 2d 790, 172 P.2d 4 (1946) (en banc); GA. CODE ANN. § 33-21-28 (1985); ILL. ANN. STAT. ch. 111, para. 4405 (Smith-Hurd 1978).

³¹¹ See Willcox, *supra* note 287, at 435.

ture.³¹² Finally, although special statutory exemptions for HMOs exist,³¹³ they do not protect other innovative forms of health care delivery.

As a result, the corporate practice doctrine has a tremendous stifling effect. Even though the instances of its exceptions outnumber its applications, its philosophy is deeply ingrained in the health care establishment in a way that pervasively affects the subliminal workings of intra-industry relationships.³¹⁴

C. *Efficiency Criteria in Physician Staffing*

Perhaps the strongest tool to achieve institutional cost control is for hospitals to penalize inefficiency by denying physicians access to a practice setting. Just as HMOs screen employees for conservative treatment styles, hospitals can begin to consider physician frugality in the process of awarding and renewing medical staff membership. Traditionally, hospitals have based their granting of admitting privileges only on quality-of-care considerations.³¹⁵ A significant number of hospitals, however, will soon begin to review physician efficiency as well during the credentialing process.³¹⁶

³¹² See, e.g., Veatch, *supra* note 241, at 132 (evolution of for-profit enterprise in health care presents numerous new forms of physician participation); cf. FOR-PROFIT ENTERPRISE IN HEALTH CARE, *supra* note 34, at 174-75 (citing statistics showing rapid growth of hospitals hiring physicians as employees and contractors).

³¹³ See 42 U.S.C. § 300e-10a (1982); GA. CODE ANN. § 33-21-28 (1982).

³¹⁴ According to recent empirical work, state restrictions on the corporate employment of physicians, ambiguous or not, hinder the growth of HMOs more than any other state regulation. See Welch, *supra* note 289, at 754-55.

³¹⁵ See, e.g., Note, *Medical Staff Membership Decisions: Judicial Intervention*, 1985 U. ILL. L. REV. 473, 477.

³¹⁶ See FOR-PROFIT ENTERPRISE IN HEALTH CARE, *supra* note 34, at 156 (admitting privileges may be at stake "[a]t an unknown number of hospitals"); B. FURROW, S. JOHNSON, T. JOST & R. SCHWARTZ, *HEALTH LAW: CASES, MATERIALS, AND PROBLEMS* 460 (1987) ("Hospitals are . . . beginning to consider revocation or limitation of staff or clinical privileges as a back-up means of control for physicians who persist in refusing to consider the cost implications of their medical care."); Hershey, *Applying Utilization Review Findings in Medical Staff Appointment and Reappointment Decisions*, *QUALITY ASSURANCE & UTIL. REV.*, Nov. 1986, at 109, 109-10 (arguing that utilization control will be of greater concern for hospitals under the new Medicare reimbursement plan).

Some hospitals may already be screening doctors for efficiency. See *Quality of Care Hearings*, *supra* note 33, at 331 ("One physician has supplied the Committee with internal hospital executive committee memoranda stating the institution's policy of threatening doctors who 'overutilize' . . . with non-renewal of their privileges at the hospital."); Cantrell & Flick, *Physician Efficiency and Reimbursement: A Case Study*, *HOSP. & HEALTH SERVS. ADMIN.*, Nov/Dec 1986, at 43, 48-50 (a study of bylaws amended by one hospital to consider economic efficiency criteria such as average length stay, average charges per admission, number of reimbursement denials, amount of bad debts generated, and adverse malpractice suits); Hull, *supra* note 35, at 33, col. 4 (reporting that president of Santa Monica Hospital "says overusers will be tolerated for

Loss of the ability to practice, either in an ambulatory or a hospital setting, is the ultimate economic sanction, equivalent to expulsion from the profession.³¹⁷ Institutions, short of totally excluding doctors, may also limit clinical privileges so that physicians cannot engage in particular areas of practice. Either form of controlling access to practice offers the hospital powerful leverage for changing physician behavior.³¹⁸ Medical staff selection presents "virtually [the] only opportunity [for the hospital] to exercise direct control over independent practitioners."³¹⁹ American hospitals are uniquely situated to exercise this influence pervasively because only in North America does the bulk of the profession practice in hospitals.³²⁰

The first reported use of a hospital program to monitor economic performance produced striking results. When efficiency screens were initially applied to physicians at Harford Memorial Hospital in Maryland, nine of 140 exceeded the criteria by more than fifteen percent. After the first year, only three were seriously out of compliance and only one of those had not shown dramatic improvement. During that year, the average length of stay for patients of the highest utilizers at Harford dropped from twenty-nine percent above to eleven percent below the statewide norm.³²¹

1. The Case Against Efficiency-Based Selection

The determinative legal question is whether physician exclusion decisions will survive judicial scrutiny if they are based on the institution's judgment of when the costs of admittedly beneficial care are excessive. Past experience counsels extreme care in treading on physicians' economic turf. The law has displayed uncommon solicitude toward physicians refused medical staff privileges by nurturing the

about six months before privileges to perform certain treatments are reviewed").

³¹⁷ See Egdahl & Taft, *supra* note 192, at 60 (exclusion from Medicare program represents ultimate sanction); Sigmond, *The Notion of Hospital Incentives*, in *HEALTH SERVICES MANAGEMENT: READINGS AND COMMENTARY* 254, 258 (A. Kovner & D. Neuhauser eds. 1978) (a practicing physician needs hospital privileges).

³¹⁸ Selectivity of medical staff is the technique that probably best accounts for HMO success. See Meier & Tillotson, *supra* note 192, at 53-54, 73-75. Physicians who favor conservative treatment naturally tend to select a compatible practice environment, and HMOs screen physicians with the same philosophy in mind. See Luft, *supra* note 176, at 512.

³¹⁹ Havighurst, *supra* note 93, at 1075 n.12 ("A hospital lacking freedom to hire and fire . . . on a discretionary basis is reduced to using persuasion as a managerial device.").

³²⁰ Elsewhere, the European model prevails, in which only a select group of specialists maintain a hospital practice. See Glaser, *American and Foreign Hospitals*, in *THE HOSPITAL IN MODERN SOCIETY*, *supra* note 261, at 54.

³²¹ See Cantrell & Flick, *supra* note 316, at 48-49.

growth of several doctrines that protect physicians' access to private hospitals and other medical institutions.³²²

Courts have consistently ruled that medical staff exclusions "must be . . . rationally related to the maintenance of quality hospital care."³²³ An exclusion is invalid if it is based on the self-interested economic motives³²⁴ of existing physicians who desire to protect their practice.³²⁵ The widely influential standards of the Joint Commission on Accreditation of Healthcare Organizations ("JCAH") similarly require that evaluative criteria be "designed to assure . . . that patients will

³²² See Comment, *Procedural Due Process Rights of Physicians Applying for Hospital Staff Privileges*, 17 LOY. U. CHI. L.J. 453, 456-67 (1986); Note, *supra* note 315, at 475-76, 479-82.

Although the case law has focused on *hospital* medical staff privileges, much of its reasoning is readily transferrable to HMOs or any other institution that selectively chooses physicians. See Cruz, *The Duty of Fair Procedure and the Hospital Medical Staff: Possible Extension in Order to Protect Private Sector Employees*, 16 CAP. U.L. REV. 59, 79-85 (1986) (advocating expansion of law). Indeed, California courts appear to have taken this step already. See *Ezekial v. Winkley*, 20 Cal. 3d 267, 270, 572 P.2d 32, 34, 142 Cal. Rptr. 418, 420 (1977) (extending judicial scrutiny to a medical resident's loss of employment in a hospital owned and operated by the Kaiser-Permanente HMO system).

³²³ Hein, *Hospital Staff Privileges and the Courts: Practice and Prognosis*, 34 FED. INS. COUNS. Q. 157, 172 (1984); see also A. SOUTHWICK, *THE LAW OF HOSPITAL AND HEALTH CARE ADMINISTRATION* 609 (2d ed. 1988) ("[T]he sole general guideline for policy in making medical staff appointments and defining privileges should be the quality of professional care rendered in the light of the hospital's objectives and capabilities."); Kessenick & Peer, *Physicians' Access to the Hospital: An Overview*, 14 U.S.F. L. REV. 43, 54-55 (1979) (listing judicially acceptable grounds for denying hospital staff privileges).

³²⁴ Courts are particularly sensitive to economic motives in antitrust actions. See Dolan & Ralston, *Hospital Admitting Privileges and the Sherman Act*, 18 HOUS. L. REV. 707, 734 (1981) (Most successful antitrust actions occur in "retaliatory denial" cases when "the medical staff uses its control over admitting privileges to enforce the economic . . . code of the dominant sector of the profession.").

³²⁵ See, e.g., *Miller v. Eisenhower Medical Center*, 27 Cal. 3d 614, 632, 614 P.2d 258, 269, 166 Cal. Rptr. 826, 837 (1980) (holding that a physician's abrasive personality could not be used as grounds to exclude him from the medical staff because there was no evidence that the physician "would pose a realistic and specific threat to the quality of medical care to be afforded patients at the institution"); *Yellen v. Board of Medical Quality Assurance*, 174 Cal. App. 3d 1040, 1059, 220 Cal. Rptr. 426, 436 (1985) ("[H]ospital staff privileges may not be denied on the grounds of . . . personality traits, unless there is some nexus between the personality trait and the quality of medical services provided."); *Nanavati v. Burdette Tomlin Memorial Hosp.*, 107 N.J. 240, 253-55, 526 A.2d 697, 703-05 (1987) (a doctor's conduct must actually interfere with patient care to justify terminating staff privileges).

Only California and New Jersey courts, however, have been so demanding on personality-based denials. Other courts generally allow dismissal for failure to cooperate. See generally Hollowell, *Physicians' Disruptive Behavior: Grounds for Discipline*, 11 LAW MED. & HEALTH CARE 25, 25-26 (1983) (surveying cases); Springer & Casale, *Hospitals and the Disruptive Health Care Practitioner—Is the Inability to Work with Others Enough to Warrant Exclusion?*, 24 DUQ. L. REV. 377, 413-19 (1985) (same).

receive quality care.”³²⁶ In some states, the enabling acts for public hospitals and the licensure statutes for private hospitals similarly restrict the allowable grounds for medical staff membership.³²⁷

If medical staff admittance standards must be based exclusively on quality of care, then denials of privileges could not be based on rendering care that potentially has any net medical benefit, regardless of the cost.³²⁸ A requirement that hospitals reject only low quality physicians clearly precludes rejection based on excessive quality.³²⁹

Recent federal legislation illustrates this single-minded focus on quality in staff privilege laws by inhibiting the use of efficiency criteria in a different manner. In order to foster vigorous peer supervision, the Health Care Quality Improvement Act of 1986³³⁰ immunizes credentialing decisions from state and federal laws if the decisions are properly rendered “in the reasonable belief that the action was in the furtherance of quality health care.”³³¹ This legislation addresses only the quality aspect of privileges review, however. It adamantly excludes protection for any consideration other than “conduct [that] affects or could affect adversely the health or welfare of a patient.”³³² Therefore, it

³²⁶ JOINT COMMISSION ON ACCREDITATION OF HOSPITALS, ACCREDITATION MANUAL FOR HOSPITALS 1988, at 112, 119 (1987) [hereinafter “JCAH ACCREDITATION MANUAL”].

³²⁷ See, e.g., CAL. HEALTH & SAFETY CODE § 1316(a) (West 1979) (privileges for the practice of podiatry may be limited “only upon the basis of an individual practitioner’s demonstrated competence”); WIS. STAT. ANN. § 50.36(3)(a) (West 1987) (“Each individual hospital shall retain the right to determine whether the applicant’s training, experience and demonstrated competence is sufficient to justify the granting of hospital staff privileges.”); see also *Rosner v. Eden Township Hosp. Auth.*, 58 Cal. 2d 592, 597, 375 P.2d 431, 439, 25 Cal. Rptr. 551, 554 (1962) (hospitals precluded from adopting “standards of fitness in addition to those enumerated” in statute); *Dooley v. Barberton Citizens Hosp.*, 11 Ohio St. 3d 216, 222, 465 N.E.2d 58, 64 (1984) (Ohio statute “R.C. 3701.351 prohibits a hospital from adopting standards for staff membership or clinical privileges that are not reasonably related to accepted measures of skill, education and competence.”); cf. *Posner v. Lankenau Hosp.*, 645 F. Supp. 1102, 1117 (E.D. Pa. 1986) (“No applicant may be denied medical staff privileges on the basis of any criterion lacking professional or ethical justifications.”).

³²⁸ “It is doubtful that a court would go along with [efforts to remove costly practitioners] since dismissal from a hospital staff has been held to be appropriate only when the physician’s . . . actions are deemed to significantly adversely affect the quality of patient care.” Gregory, *DRGs Part 2—Possible Legal Consequences for the Physician*, LEGAL ASPECTS MED. PRAC., Apr. 1986, at 1, 2 (1986).

³²⁹ Some might contend that excessive treatment is poor quality practice, as in the case of unnecessary surgery. This limited justification, however, is effective only with procedures that have a net adverse medical risk. It would not suffice with marginally justifiable care that is not worth the cost, such as extended hospital stays or routine admission X-rays.

³³⁰ Pub. L. No. 99-660, 100 Stat. 3784 (codified at 42 U.S.C. §§ 11101-11152 (Supp. IV 1986)).

³³¹ 42 U.S.C. § 11112(a)(1) (Supp. IV 1986).

³³² *Id.* § 11151(9).

"has no bearing on peer review of fees or utilization for cost-containment purposes."³³³ This exclusion of cost considerations from one of the most important pieces of health care legislation in recent years illustrates once again the depth of the schizophrenia that affects federal health care policy.³³⁴

2. The Case in Favor of Efficiency Criteria

The law's past emphasis on quality considerations in physician staffing decisions is an artifact of the industry's own quality fetish.³³⁵ Now that hospitals are beginning for the first time to incorporate cost considerations in their business decisions, the validity of efficiency criteria must be examined *de novo*.³³⁶ Fortunately, this issue does not have to be addressed in a policy bell jar evacuated of precedent. A closer reading of the established case law reveals a number of strong bases for including cost considerations in the credentialing process.

The case law does not mandate quality as the touchstone for all privileges decisions. The established judicial standard broadly allows criteria related to "sound hospital standards" and "in furtherance of the common good."³³⁷ Moreover, the JCAH standard does not mean to

³³³ Havighurst, *Professional Peer Review and the Antitrust Laws*, 36 CASE W. RES. L. REV. 1117, 1162 (1986).

³³⁴ Congress failed to realize that efficiency-based privileges decisions merit the same protection as quality decisions. The cost crisis in health care is of a proportion that at least equals the malpractice crisis. More fundamentally, the malpractice crisis is itself a cost crisis caused by the insurance industry sharply increasing premiums, thus fueling medical inflation. See Nelson, *Medical Malpractice and the Transformation in Health Care Delivery*, 17 CUMB. L. REV. 313, 313 (1987). Physician reaction to the crisis mentality is to practice defensively, resulting in more expenditures. The federal government's solution is an indirect one. It attempts to suppress these reactions by fostering heightened scrutiny of physician quality. Congress ignored the opportunity to strike directly at health care costs by fostering heightened efficiency monitoring.

³³⁵ "[C]ourts have treated [quality of care] as the standard by which most medical staff appointments are judged, probably because there have been few other grounds that hospitals have considered in the privileging process." Eller & Teplitzky, *Considering Economic Factors in Hospital Privilege Decisions*, HEALTH SPAN, Aug.-Sept. 1986, at 11, 11.

³³⁶ Cf. *Massachusetts Medical Soc'y v. Dukakis*, 637 F. Supp. 684, 704-07 (D. Mass. 1986) (regulations directed at the economics of the profession could be considered rationally related to a doctor's "fitness or capacity" to practice (citing *Schwartz v. Board of Bar Examiners*, 353 U.S. 232 (1957)), *aff'd*, 815 F.2d 790 (1st Cir.), *cert. denied*, 108 S. Ct. 229 (1987)).

³³⁷ *Greisman v. Newcomb Hosp.*, 40 N.J. 389, 403-04, 192 A.2d 817, 825 (1963); see also *Desai v. St. Barnabas Medical Center*, 103 N.J. 79, 90-91, 510 A.2d 662, 668 (1986) ("Hospital powers . . . must be exercised reasonably for the public good . . ."); *Davidson v. Youngstown Hosp. Ass'n*, 19 Ohio App. 2d 246, 250, 250 N.E.2d 892, 895 (1969) ("The power . . . to pass on staff membership applications . . . must be exercised reasonably and for the public good."); *Woodard v. Porter Hosp., Inc.*, 125 Vt. 419, 423, 217 A.2d 37, 40 (1966) (same) (quoting *Davidson*, 19 Ohio

exclude cost considerations by specifying quality as a legitimate hospital purpose for physician exclusion. Rather, the standard takes an open-ended view of the permissible "professional criteria," allowing them to "pertain to other reasonable qualifications."³³⁸

Lowering the cost of medical care is an undeniably compelling hospital and societal purpose.³³⁹ It is the driving force behind the variety of federal and state legislative programs that foster reductions in health care spending.³⁴⁰ Denuding hospitals of an essential tool for economic survival in an era of restrained reimbursement would be irresponsible and self-defeating.³⁴¹

Courts that reject economic motivation in staff selection decisions are concerned with the physician's, not the hospital's, interests. Courts scrutinize economic factors because of the danger that existing staff physicians will use their influence over hospital access to harm their competitors.³⁴² Hospitals that screen for inefficient physicians, however, promote rather than retard the goals of competition. Hospitals should be free, then, to act out of their own economic interest, particularly when that interest is congruent with the public interest.³⁴³ This principle is established by cases that sustain hospital requirements that staff members maintain a certain level of malpractice insurance coverage. These courts have validated hospital self-interest by holding that hospitals have the "right to take reasonable measures to protect [themselves]"

App. 2d at 250, 20 N.E.2d at 895)).

³³⁸ JCAH ACCREDITATION MANUAL, *supra* note 326, at 112, 119.

³³⁹ See Marsh, *supra* note 58, at 188 ("An understanding of the concept of common good certainly includes the hospital's ability to successfully implement . . . cost containment programs . . . so that the general needs of the community may be met."); cf. *Massachusetts Medical Soc'y*, 637 F. Supp. at 706 (stating that "containment of medical costs for the elderly is plainly a legitimate concern of the Commonwealth").

³⁴⁰ See, e.g., *Desai*, 103 N.J. at 88, 510 A.2d at 666 ("The Legislature itself has expressly declared in the Health Care Facilities Planning Act . . . that 'hospital and related health care services of the highest quality, of demonstrated need, *efficiently provided and properly utilized at a reasonable cost* are of vital concern to the public health.'" (emphasis added)) (quoting N.J. STAT. ANN. § 26:2H-1 (West 1987)).

³⁴¹ Cf. *Massachusetts Medical Soc'y*, 637 F. Supp. at 706 ("Nothing in the case law . . . attributes to 'fitness or capacity to practice' [for doctors] the narrow definition advocated by plaintiffs. . . . [The state must have] some latitude in choosing what it considers to be necessary indications of fitness and capacity.").

³⁴² See Havighurst & King, *Private Credentialing of Health Care Personnel: An Antitrust Perspective*, 9 AM. J.L. & MED. 131, 162 n.95 (1985).

³⁴³ Preventing hospitals from acting out of their own interests would undermine the very incentive structure that drives the credentialing process we rely on to screen physician competence. It is ultimately hospital self-interest that motivates traditional quality-based exclusions because hospital admissions depend heavily on the institution's reputation for quality. Hospitals, when selecting medical staff members in an era of cost containment, should continue to be free to act out of their own best interests.

from joint and several liability with physicians.³⁴⁴

More directly on point, courts have upheld, in specific instances, the hospital's use of efficiency criteria to deny physicians staff privileges.³⁴⁵ The most frequent examples are decisions approving exclusive arrangements with radiologists and anesthesiologists.³⁴⁶ The courts agree that the closed staff operations are "more economical and permit[] services to patients at a lower cost."³⁴⁷ Even more squarely on point, a scattering of decisions uphold denials based expressly on individual physician overutilization of hospital resources.³⁴⁸

³⁴⁴ *Holmes v. Hoemako Hosp.*, 117 Ariz. 403, 405, 573 P.2d 477, 479 (1977) (noting that hospitals have a right to act in their own interest); *see also Kelly v. St. Vincent Hosp.*, 102 N.M. 201, 205, 692 P.2d 1350, 1354 (Ct. App. 1984) (recognizing a hospital's legitimate business purposes, such as saving on insurance coverage, as valid considerations in a decision to require physicians to carry malpractice insurance); Bernstein, *Medical Staff Privilege Disputes*, HOSPITALS, Apr. 16, 1984, at 85, 88 (the hospital's requirement "that staff members be adequately insured is for protection of the facility's . . . assets, not necessarily for protection of the patient").

³⁴⁵ Also, a few states have passed statutes allowing the use of efficiency criteria. *See* N.C. GEN. STAT. § 131E-85 (1986) ("appropriate utilization of hospital facilities" may be considered); VA. CODE ANN. § 32.1-134.1 (1985) (the reasons must be related to "the objectives or efficient operation of the institution"); *cf.* N.Y. PUB. HEALTH LAW § 2801-b(1) (McKinney 1985) ("the objectives of the institution" may be considered), *considered in Hauptman v. Grand Manor Health Related Facility*, 121 A.D.2d 151, 153, 502 N.Y.S.2d 1012, 1015 (1986) (institutional objectives must be "reasonable").

³⁴⁶ *See, e.g., Dattilo v. Tucson Gen. Hosp.*, 23 Ariz. App. 392, 397-98, 533 P.2d 700, 705-06 (1975) (exclusive contract for nuclear medicine treatment); *Centro v. Roseville Community Hosp.*, 107 Cal. App. 3d 62, 73-74, 167 Cal. Rptr. 183, 189 (1979) (exclusive radiology contract); *Radiology Professional Corp. v. Trinidad Area Health Ass'n*, 195 Colo. 253, 258, 577 P.2d 748, 752 (1978) (hospital administrators may enter into exclusive medical service contracts under certain circumstances); *see also Kessenick & Peer, supra* note 323, at 63-74 (analyzing exclusive contracts).

³⁴⁷ *Lewin v. St. Joseph Hosp.*, 82 Cal. App. 3d 368, 389, 146 Cal. Rptr. 892, 905 (1978); *see Dattilo*, 23 Ariz. App. at 396, 533 P.2d at 704 ("[S]uch contracts [are] needed for control and standardization of procedure and effective, efficient operation of the department. . . . [T]hey give the Board of Trustees great ability to monitor the departments to insure that the standard is being maintained because of the more limited number of people actually participating . . .").

³⁴⁸ *See, e.g., Friedman v. Delaware County Memorial Hosp.*, 672 F. Supp. 171, 178, 179 (E.D. Pa. 1987) (granting summary judgment to hospital which excluded doctor based on "overutilization of bronchoscopies" and "evasion of Utilization Review Committee recommendations"), *aff'd mem.*, 849 F.2d 600 (3d. Cir. 1988); *Suckle v. Madison Gen. Hosp.*, 362 F. Supp. 1196, 1200 (W.D. Wis. 1973) (upholding exclusion based on "a 'general conclusion' that plaintiff had improperly utilized hospital beds [and] performed unnecessary surgery and diagnostic procedures"), *aff'd*, 499 F.2d 1364 (7th Cir. 1974); *Anton v. San Antonio Community Hosp.*, 19 Cal. 3d 802, 809, 567 P.2d 1162, 1164, 140 Cal. Rptr. 442, 444 (1977) (upholding exclusion based on committee report that many of a doctor's patients "did not appear to need actual hospital care" and that the doctor performed "multiple tests . . . without medical indication"); *Knapp v. Palos Community Hosp.*, 125 Ill. App. 3d 244, 251, 465 N.E.2d 554, 560 (1984) (upholding exclusion based on physician's "overutilization . . . result[ing] in hospitalizations that were 50% longer and costs that were 31% greater than [the norm]").

Nevertheless, health care institutions continue to face an uncomfortable level of legal uncertainty in adding aggressive utilization screens to their staff selection process. The case law remains firmly grounded in quality concerns; no case cleanly supports the exclusion of physicians because of factors wholly unrelated to quality of care, much less opposed to quality.³⁴⁹ Courts justify exclusive radiology and anesthesiology contracts because of their ability to enhance training and supervision.³⁵⁰ Membership refusals based on overcrowding are "motivated by the Trustees' unwillingness to permit the quality of patient care . . . to deteriorate—an occurrence they deem[] inevitable if the facility were overtaxed by additional surgical cases."³⁵¹ Even those decisions that appear to rely most squarely on physician overutilization ultimately fall back on quality of care concerns such as the harms caused by unnecessary surgery.³⁵²

3. The Implementation of Efficiency Criteria

Those hospitals with the courage to pioneer the use of medical staff efficiency screens, despite their uncertain validity, must ultimately consider how to implement the screening process. Hospitals may not rely on an internal common law of membership qualification. When

Courts have also found that privilege denials may be justified when they are based upon hospital "overutilization" concerns when departments or hospitals close because of overcrowding. See *Berman v. Valley Hosp.*, 103 N.J. 100, 114, 510 A.2d 673, 680 (1986) (hospital could deny privilege but specific program was arbitrary and unenforceable); *Desai v. St. Barnabas Medical Center*, 103 N.J. 79, 93-94, 99, 510 A.2d 662, 669-70, 672 (1986) (same); *Davis v. Morristown Memorial Hosp.*, 106 N.J. Super. 33, 53-54, 254 A.2d 125, 137 (Ch. 1969) (upholding hospital's policy of no staff admissions for obstetricians and gynecologists). These decisions are not directly applicable, however, because they deal with hospital rather than physician overutilization.

³⁴⁹ For instance, although malpractice insurance requirements are partly justified by the hospital's economic interest, they are also supported by reasoning that ultimately reflects patient welfare. "[N]ot carrying malpractice insurance might adversely affect patient care in the hospital in that uninsured physicians might avoid participating in the care of hospital patients with serious medical or surgical problems . . ." *Holmes v. Hoemako Hosp.*, 117 Ariz. 403, 404, 573 P.2d 477, 478 (1977) (quoting affidavit of Hoemako Hospital Administrator).

³⁵⁰ See *Dattilo*, 23 Ariz. App. at 396, 533 P.2d at 704 ("[B]etter patient care [under exclusive contracts] is achieved because of better scheduling and higher quality of results . . ."); cf. *Jefferson Parish Hosp. v. Hyde*, 466 U.S. 2, 5 (1984) (citing trial court's conclusion that anticompetitive consequences of exclusive contract were outweighed by "benefits in the form of improved patient care").

³⁵¹ *Guerrero v. Burlington County Memorial Hosp.*, 70 N.J. 344, 358, 360 A.2d 334, 341 (1976).

³⁵² See *Friedman*, 672 F. Supp. at 180; *Anton*, 19 Cal. 3d at 810-11, 567 P.2d at 1164-65, 140 Cal. Rptr. at 444-45; see also Miller, *Use of Hospital Data in Medical Staff Discipline*, in 1 TOPICS IN HOSPITAL LAW 37, 39 (1985) ("There are numerous examples of discipline for overutilization *contrary to quality care.*" (emphasis added)).

physicians challenge credentialing decisions, courts will scrutinize the medical staff bylaws to ensure that the institution duly promulgated and followed the published selection criteria.³⁵³ Therefore, "it is likely that medical staff bylaws will have to be amended to provide appropriate disciplinary action for nonconformance with approved patient treatment standards."³⁵⁴

This requirement presents a substantial obstacle because doctors, not hospitals, control the medical staff bylaws.³⁵⁵ The AMA has al-

³⁵³ See, e.g., *McElhinney v. William Booth Memorial Hosp.*, 544 S.W.2d 216, 218 (Ky. 1976) (holding that a hospital "cannot revoke the staff privileges of a physician in the absence of a sufficiently definite standard proscribing the conduct for which revocation is adjudged."); *Miller v. Indiana Hosp.*, 277 Pa. Super. 370, 375, 419 A.2d 1191, 1193 (1980) (noting "strict compliance" with bylaws is required). What constitutes a "sufficiently definite standard" may be problematic. Hospitals may not be able to rely on general requirements of professional competence. See *McElhinney*, 544 S.W.2d at 218 (holding that a hospital could not discipline an uncooperative physician under a bylaw provision proscribing "professional incompetence"); see also *Wyatt v. Tahoe Forest Hosp. Dist.*, 174 Cal. App. 2d 709, 715, 345 P.2d 93, 97 (1959) (noting that a hospital rule admitting only physicians who can provide "the best possible care[]" is too vague and uncertain to be used as the basis for the exclusion of an applicant").

³⁵⁴ Reiss, *Legal Issues Arising From the Medicare Prospective Payment Plan*, in *THE MEDICARE SYSTEM OF PROSPECTIVE PAYMENT* 93, 104 (M. Garg & B. Barzansky eds. 1986). Only a small number of bylaws contain explicit efficiency criteria. See Barry, *supra* note 35, at 42 (noting that most medical staff bylaws do not prohibit costly utilization of patient services); Bernstein, *supra* note 344, at 88 ("[N]o hospital bylaws currently call for disciplining an overzealous prescriber when quality of care is not jeopardized . . ."); Glandon & Morrissey, *supra* note 225, at 171 (noting that one percent of bylaws require physician applicants to provide evidence of cost-effective care).

One author suggests language that grants privileges to "physicians . . . who . . . demonstrate to the staff and the board that they will provide care to patients at the generally recognized professional level of quality, in an economically efficient manner, taking into account patients' needs, the available hospital facilities and resources, and utilization standards in effect at the hospital." Hershey, *Revising Medical Staff Bylaws: An Organizational Challenge*, *LAW, MED. & HEALTH CARE*, Fall 1987, at 139, 141. A prominent health care law firm recommends the following language:

Only physicians . . . who . . . provide quality care . . . in an economical and efficient manner without adversely affecting the financial viability of the hospital . . . shall be eligible for membership on the medical staff. . . . Provided, however, that (i) prudent and appropriate care of patients shall have priority over the financial viability of the hospital, . . . (iii) determinations of failure to satisfy this qualification shall be based primarily (but not exclusively) on appropriate comparisons of the practitioner's practice patterns with [] practitioner practice patterns [accepted] . . . by the medical executive committee and/or the [hospital board of directors].

Form obtained June 1988 from Julie R. Fortin and Robert W. Miller of King & Spalding, Atlanta, Georgia.

³⁵⁵ See W. CURRAN & E. SHAPIRO, *LAW, MEDICINE, AND FORENSIC SCIENCE* 626 (3d ed. 1982) ("The division of responsibilities [between hospital governing boards and medical staffs] makes it difficult for governing bodies to influence changes in patient care procedures . . . and to impose cost-control programs on a reluctant medical staff."). A second difficulty of implementation is that, if cost containment criteria are successfully enacted, they still require physician participation for enforcement. See *id.*

ready stated its opposition to efficiency criteria or any other screening device that seeks to bring physicians within the DRG incentive structure.³⁵⁶ The JCAH also demonstrated its sensitivity to this issue by revising its 1988 *Accreditation Manual for Hospitals* to state explicitly that "[n]either body may unilaterally amend the medical staff bylaws."³⁵⁷ Thus, any hospital attempt to circumvent physician opposition by amending medical staff bylaws on its own initiative will jeopardize its accreditation status and will fail in court.³⁵⁸

On balance, the prospects are discouraging for medical institutions to base physician selection on economy of practice style, the control technique of last resort. After overcoming the uncertainties of substantive validity, medical institutions must still face the daunting task of implementation. Doctors can block implementation or thwart vigorous enforcement because they firmly control the hospital credentialing process. Ultimately, then, it is the structural allocation of authority within the hospital that most frustrates institutional cost containment. Therefore, the final section of this Article will examine more closely the obstacles to structural reform of the hospital medical staff.

at 626-27.

³⁵⁶ See AMA Judicial Council, *supra* note 244, at 2425 ("[A] physician should not be financially penalized or placed in jeopardy of his hospital privileges because DRG allowances to the hospital were insufficient to cover hospital stays . . ."). At one hospital, economic efficiency criteria "were roundly denounced by the medical staff, which . . . petitioned the Board of Directors for their recall." Cantrell & Flick, *supra* note 316, at 48.

³⁵⁷ JCAH ACCREDITATION MANUAL, *supra* note 326, at 114. The hospital industry's initiative to revise JCAH standards so that hospitals retain final authority over medical staff bylaws was "vigorously oppose[d]" by the AMA. See *AMA Convention Medical Staff Highlights*, HOSPITALS, Aug. 5, 1987, at 58, 58.

³⁵⁸ See *St. John's Hosp. Medical Staff v. St. John Regional Medical Center*, 90 S.D. 674, 681, 245 N.W.2d 472, 475 (1976) (striking down a hospital's unilateral amendment of the medical staff bylaws because the bylaws also required medical staff approval), discussed in Curran, *Hospital Power and Medical Responsibility: Medical-Staff Bylaws*, 296 NEW ENG. J. MED. 264, 264-65 (1977).

One hospital attempted to evade this barrier by implementing efficiency criteria in the hospital's bylaws as a supplement to the medical staff bylaws. See Cantrell & Flick, *supra* note 316, at 45. Even if this tactic were legally permissible, it would run afoul of the powerfully influential JCAH accreditation standards, which require that credentialing criteria be contained in the medical staff bylaws. See JCAH ACCREDITATION MANUAL, *supra* note 326, at 102, 108-09.

Another suggested technique, which has greater merit, is for the hospital to provide the medical staff with notice and an opportunity to comment on proposed hospital changes to the medical staff bylaws. According to one commentator, this technique may be sufficient to meet the JCAH nonunilateral requirement. Hershey, *supra* note 354, at 142. Limiting the medical staff's input on bylaw changes to an advisory role, however, may itself require medical staff approval, depending on the current terms of the bylaws.

D. *Hospital Reorganization and the Autonomous Medical Staff*

1. Demise of the Traditional Medical Staff

Many management techniques envision nontraditional medical staff structures as alternatives to the independent, open, self-governing model that currently prevails. For instance, hospital management may have to assume control of the credentialing process in order to implement efficiency screening. Separating the medical staff into an independent entity that forms a joint venture with the hospital in order to create financial incentives for more economical care also entails a departure from the traditional model. Finally, to give hospitals greater control over the details of practice, many commentators envision hospitals that will no longer consist of two separate lines of authority—one with control over financial matters and one with control over clinical matters. The two would be merged into a single, hierarchical bureaucracy, similar to European hospitals.³⁵⁹ In short, this radical proposal calls for the outright demise of the self-governing medical staff.³⁶⁰

2. Institutionalization of the Medical Staff

Physicians can be expected to show intense opposition to full-scale bureaucratization of the hospital. "The hierarchical authority structure characteristic of bureaucratic organization as delineated by Weber clearly conflicts with the physician's role expectations"³⁶¹ "By definition, professionals and bureaucracies are incompatible in principle. . . . Essentially, science needs autonomy, whereas organizations need integration."³⁶²

Nevertheless, if medical staff independence were simply a matter of private industry custom, organizational change might be attainable. To the contrary, though, the two lines of authority that so frustrate hospital administrators and students of organization theory³⁶³ are entrenched in the law. Most state hospital licensure statutes require hospitals to grant their medical staffs semi-autonomous existence with for-

³⁵⁹ See Scott, *supra* note 72, at 223, 226.

³⁶⁰ See Shortell, *supra* note 223, at 92, 95.

³⁶¹ Goss, *supra* note 261, at 176.

³⁶² Marylander, *supra* note 170, at 13; see also E. FREIDSON, *supra* note 55, at 159 ("[T]here is an intrinsic conflict between Weber's concept of rational-legal bureaucracy and the Anglo-American concept of professionalism."); W. KORNHAUSER, *supra* note 110, at 13 ("The determination of how professional work shall be conducted . . . entails a conflict between the hegemony of the organization and the autonomy of the profession.").

³⁶³ See *supra* notes 276-82 and accompanying text.

mal bylaws separate from the hospital's bylaws.³⁶⁴ Thus, the law perpetuates the anomalous institutional structure of a firm within a firm.

A hospital could still theoretically exercise control over a separately organized medical staff. Large corporations, for example, are structured as classic hierarchies despite formal internal divisions. Hospitals, however, are unique because state licensure statutes impose the additional element of self-governance. Those statutes preserve medical staff autonomy completely by ensuring that the staff has exclusive or substantial control over vital aspects of hospital operations. Critically, the medical staff has the self-perpetuating power to determine its own membership.³⁶⁵ This legislated power over its own destiny gives the medical staff effective veto power over attempts to reformulate hospital structure. Physicians can frustrate the hospitals' unilateral attempts to choose medical staff members contrary to physician desires, and they can prevent hospitals from independently changing their staff from an open to a closed model, or from independent practitioners to employees.

To the extent that state laws do not explicitly promote medical staff self-governance, the same effect is accomplished through the JCAH accreditation standards, which are thoroughly enmeshed in the public regulatory process.³⁶⁶ JCAH standards decree an organized

³⁶⁴ See generally AMERICAN HOSPITAL ASSOCIATION, *supra* note 10 (fifty-state compendium of statutes and regulations controlling organized medical staff).

³⁶⁵ See, e.g., CAL. HEALTH & SAFETY CODE § 32128 (West Supp. 1988) (stating that the medical staff "shall be self-governing with respect to the professional work performed in the hospital"); FLA. ADMIN. CODE ANN. r. 10D-28.156(4) (1986) ("No action on appointment . . . or dismissal shall be taken without prior referral to the organized medical staff for their recommendation . . .").

³⁶⁶ Several states mandate JCAH accreditation; many others allow the private accreditation process to serve in lieu of state licensure. See Roberts, Coale & Redman, *A History of the Joint Commission on Accreditation of Hospitals*, 258 J. A.M.A. 936, 939 (1987) (noting that 39 states and the District of Columbia have incorporated in varying degrees the JCAH standards into their hospital licensure statutes); see also M. MACDONALD, K. MEYER & B. ESSIG, *HEALTH CARE LAW: A PRACTICAL GUIDE* § 5.03[2] (1988) (stating that several additional states are considering incorporation of JCAH standards into their licensure statutes). Moreover, the Medicare program deems JCAH-approved hospitals qualified to participate without further inspection. See 42 U.S.C. § 1395bb (1982 & Supp. IV 1986); see also Jost, *The Joint Commission on Accreditation of Hospitals: Private Regulation of Health Care and the Public Interest*, 24 B.C.L. REV. 835, 845 & nn. 70, 71, 74 (1983) (JCAH accreditation required for insurance coverage of certain forms of treatment in Ohio and Oregon, for state mental hospitals and university hospitals in Ohio, and for approval of residency programs throughout the nation).

Even without this statutory imprimatur, the JCAH, as the sole hospital accrediting organization, effectively has plenary authority over the structure of American hospitals. See Havighurst & King, *supra* note 342, at 323. Almost no hospital of significant size will risk the business consequences of operating without its seal of approval. See Jost, *supra*, at 845 ("Virtually all hospitals with more than twenty-five beds" are

medical staff whose bylaws "establish a framework for self-governance."³⁶⁷ Notably the medical staff must have substantial authority over membership selection: it alone conducts the credentialing process that is the basis for determining admitting and treating privileges.³⁶⁸

3. Blocked Institutional Development

Because the JCAH model of the open, self-governing medical staff is so entrenched in American hospitals, some tend to view it as inevitable, or at least superior to the alternatives.³⁶⁹ Others take a different view, maintaining it is the root of inefficiency in American medicine.³⁷⁰ Undoubtedly, both accounts contain some truth. After all, the American medical system is the world's most highly developed, but also the world's most expensive. In either event, the American model, duplicated only in Canada,³⁷¹ tells us at least that other models are feasible. Therefore, a deeper understanding of the values served by the JCAH model requires an understanding of the origins of the hospital and the hospital accreditation movement.

In 1919, the recently formed American College of Surgeons, seeing the need for standardization of surgical practices and credentials, implemented what was to grow quickly into a full-blown hospital accreditation movement.³⁷² It established a set of hospital standards governing the requirements for an approved surgical practice. In setting these standards, it essentially shaped the hospital/physician structure that existed at the time³⁷³ to meet its own ends: the open hospital medical staff

JCAH accredited.).

³⁶⁷ JCAH ACCREDITATION MANUAL, *supra* note 326, at 114.

³⁶⁸ See *id.* at 112, 119. The AMA is lobbying to expand JCAH medical staff protections even further by removing hospital control over the selection of medical directors and department chairmen and requiring medical staff approval for changes in even the hospital's bylaws. See Chapman-Cliburn, *AMA Addresses Medical Staff Self-Governance*, HOSPITALS, Jan. 20, 1988, at 54, 54.

³⁶⁹ See AMA/AHA JOINT TASK FORCE, *supra* note 102, at 11 (The self-governing medical staff "is an essential strength in the American health care system that should not be lost or sacrificed to outside pressures.").

³⁷⁰ See Havighurst, *supra* note 93, at 1087; Havighurst & King, *supra* note 342, at 324 n.173.

³⁷¹ See AMA/AHA JOINT TASK FORCE, *supra* note 102, at 10-11.

³⁷² See Jost, *supra* note 366, at 845-49 (describing the development of the American College of Surgeons' Hospital Standardization Program).

³⁷³ The following synopsis of the origin is extrapolated primarily from two relatively brief and somewhat conflicting sketches: M. ROEMER & J. FRIEDMAN, *supra* note 30, at 33-43; P. STARR, *supra* note 30, at 162-69; see also C. ROSENBERG, *THE CARE OF STRANGERS* (1987) (history of American hospitals); D. ROSNER, *A ONCE CHARITABLE ENTERPRISE* (1982) (studying the institutional changes in New York City hospitals between 1885-1915).

In the American colonies, hospitals began as almshouses for the poor, typically

was preserved, but with the requirement that the staff be separately organized. These essential elements have been perpetuated to the present day by the JCAH (formed in 1952 by the American College of Surgeons in conjunction with the AMA, the AHA, and the American College of Physicians), which has assumed the hospital accreditation function.³⁷⁴

This history's primary lesson is that the medical profession has determined not only the terms of its interaction with hospitals but also the very structure of the hospital itself. This control was accomplished through the JCAH, three of whose four founding groups are physician associations. The hospital industry still does not have a controlling voice in the organization that sets its accreditation requirements.³⁷⁵ Not surprisingly, then, these "organizational arrangements . . . were in large part designed and forced upon the system by organized medicine" to serve the interests of physicians.³⁷⁶

operated by the government and employing a small staff of full-time doctors. People who could afford a private physician at home stayed clear of hospitals (or "asylums" as they were often called). With the advancement in surgical techniques, the development of anesthesia, and the implementation of aseptic and antiseptic procedures during the late nineteenth and early twentieth centuries, however, hospitals quickly became indispensable adjuncts to surgery. Hospitals began allowing "visiting physicians" to use the hospital facility to treat their own private, paying patients in exchange for donation of the doctors' time to treat the institution's charitable beneficiaries. As greater demands were placed on the few existing pay beds, a new form of hospital emerged that catered predominantly to middle and upper class patients. Many of these private hospitals retained their charitable affiliation, but many were organized and owned by doctors. The original almshouses, facing a loss of their supportive paying patients, responded by opening their staffs to all qualified physicians. This rapid developmental period from 1900 to 1920 was spurred by the sharp expansion of population and territorial settlement in the United States. Influenced by the American laissez-faire ethic, hospitals grew in an unstructured, open fashion, in sharp contrast to European hospitals, which continued under the employment model. The open staff model was more compatible with nineteenth century American economic conditions. The United States was demographically unable to support the European model of a profession that strictly divided roles between office-based generalists and hospital-based specialists. See Mechanic, *The Changing Structure of Medical Practice*, 32 LAW & CONTEMP. PROBS. 707, 708 (1967).

³⁷⁴ At about the same time, many of the hospital accreditation standards were codified in state licensure statutes based on a model act heavily influenced by these organizations. M. ROEMER & J. FRIEDMAN, *supra* note 30, at 40.

³⁷⁵ See *In re American Medical Ass'n*, 94 F.T.C. 701, 756 (1979) (listing numerous ways in which "JCAH accreditation standards follow AMA policy"); Roberts, Coale & Redman, *supra* note 366, at 938 (the AHA only appoints seven of 22 JCAH commissioners).

³⁷⁶ Havighurst, *supra* note 93, at 1086. The current structure serves physicians' interests in a number of ways. Doctors have avoided the power and influence that large, financially strong institutions usually exert by ensuring delegation to themselves of control over substantial segments of hospital operations. By carving out a guarantee of open access coupled with independence, physicians have secured for themselves a cost-free workplace of extraordinary technological sophistication. Neither the master

To preserve their privileged position in hospitals, physicians have created a phenomenon medical sociologist Paul Starr describes as "blocked institutional development," rendering the hospital "a pre-capitalist institution radically changed in its function and moral identity but only partially transformed in its organizational structure."³⁷⁷ In other words, the development of the independent medical staff is best described as the non-happening of an event. Doctors continue to relate to hospitals in essentially the same way they did when hospitals first became desirable places to seek medical treatment. The medical profession simply extended to the twentieth century the predominant nineteenth century format of independent, entrepreneurial practice that arose during medicine's developmental era.³⁷⁸

Cementing the JCAH medical staff model into the law is poor public policy. Mandating a single institutional structure blocks organizational innovation in response to new environmental forces. As Clark Havighurst has convincingly argued, "how a hospital is internally organized and run should be a managerial issue, not a legal one."³⁷⁹ What the optimal hospital structure is and how the institution will be transformed if public and private barriers are removed should be left to the future.³⁸⁰ If the forces of this new era are applied to an unbending structure, they will either be deflected or the structure will shatter.

V. CONCLUSION

"A strong consensus has emerged among health economists over the past couple of years that the cost-containment effort is in general a failure. Not one of the major cost-containment initiatives has yet succeeded—or shows any serious promise that it will eventually succeed. Not even the slightest downward dip of any significance has appeared on those economic charts that measure the ever-rising cost of health

nor the servant of the household, they enjoy the privileged status in the hospital of an honored guest.

³⁷⁷ P. STARR, *supra* note 30, at 179.

³⁷⁸ See Scott, *supra* note 72, at 217.

³⁷⁹ Havighurst, *supra* note 93, at 1082.

³⁸⁰ Physicians are not unduly threatened by this uncertainty because, however transformed,

[h]ospitals will always need physicians. . . . As a result, they will strive to create conditions that . . . will accommodate [physicians'] interests wherever possible. . . . [Therefore,] the intra-institutional power shifts that are occurring are simply correcting existing imbalances and will stop well short of forcing physicians into positions inconsistent with their professional and independent status.

care.”³⁸¹ There has not yet been an adequate account of what caused such initially promising programs as HMOs and Medicare prospective payment to stall so suddenly.³⁸² This Article demonstrates that the principal reason our nation’s emerging health care policy is in a shambles is that policymakers have ignored the law’s institutionalization of physician autonomy.

Contemporary reimbursement policy assigns to institutions the broad new responsibility of leading the revolution in health care cost containment. For reimbursement reform to work, hospitals, HMOs, and other health care institutions must aggressively adopt management techniques that disseminate to physicians the same efficiency incentives that prospective payment places on them. The law, however, frustrates institutional control at every turn. Lay administrators and even physician supervisors may not direct the course of treatment. The law forbids hospitals from passing their financial incentives on to physicians, and Congress is giving serious consideration to extending this ban to HMOs. The corporate practice doctrine prohibiting employment deters hospitals from employing physicians. Restricting access to medical institutions on efficiency grounds is legally uncertain and laden with discouraging legislation. General structural reform is hampered by laws that institutionalize status quo patterns.

It is troubling but not surprising to find that a revolutionary change in health care policy does not fit well with the pre-existing legal structure. It is more important to explore whether the extent to which the law protects physician independence is justified and whether the legal structure is capable through evolutionary change of absorbing the new public policy. To answer these inquiries, we have engaged in a deeper socio-political analysis of the origins of the law’s current orientation. This analysis has revealed the remarkable extent to which the law reinforces the medical profession’s interests, power, and autonomy.

A. *Physician Dominance Through the Law*

The thorough grounding of the law in the values and relationships of traditional medicine has essentially codified the ethic of professional

³⁸¹ Callahan, *Allocating Health Resources*, HASTINGS CENTER REP., Apr.-May 1988, at 14, 14.

³⁸² For instance, a recent ProPac report to Congress, see *Medicare Prospective Payment and the American Health Care System*, [June 1988] Medicare & Medicaid Guide (CCH) No. 560 (extra ed. July 26, 1988), explained that the Medicare cost per case “initially declined below inflation in the first year of PPS,” but “subsequently rose to about 10 per cent per year—6 percentage points above inflation.” The reporting committee acknowledged that it “does not completely understand why [these cost increases] have occurred.” *Id.* at 5.

sovereignty. Throughout, the law embodies the professional ideal of independent practice facilitated but unconstrained by institutional capital. The unlicensed and corporate practice prohibitions are consciously designed to prevent lay institutional interference with physician autonomy. The law goes further and protects physicians from even peer scrutiny through the tortious interference concept. Fee splitting prohibitions implicitly promote an ethic of solo, fee-for-service practice unfettered by external financial influence by inhibiting the formation of group practices, branding as unethical any financial inducement to send patients elsewhere for treatment, and directly prohibiting the use of financial incentives to influence physician practice patterns.

The law relating to medical staff privileges may be more responsive to change despite its focus on the dominating industrial and professional imperative of quality, but it still generously protects professional interests against institutional infringement with its careful scrutiny of private association membership decisions. The self-governing nature of the medical staff and its explicit control over its own destiny prevents any unilateral action by the hospital from changing the process by which staff members are selected. Both this process and the structure of the staff as a whole are fashioned to reinforce the independence of the medical staff as a separate line of authority within the hospital, to the exclusion of alternative organizational structures.

Perhaps the strongest motif that emerges from this exposition is the distinction between individual and group autonomy. "Professional autonomy is based on the belief that qualified practitioners are best able to determine how the function ought to be performed, *and* that each practitioner must be free to exercise his own judgment in the specific case."³⁸³ This dichotomy serves as a powerful organizing principle for understanding the way in which professional independence has infiltrated legal principles and medical institutions. Each of the branches of law implicated by the three classes of control techniques—directives, incentives, and reorganization—reflects careful preservation of physician autonomy in both dimensions.³⁸⁴

³⁸³ W. KORNHAUSER, *supra* note 110, at 1 (emphasis altered).

³⁸⁴ Group autonomy is protected from lay administrative rules by unlicensed and corporate practice prohibitions. Supervision from within the collegium, which is not threatening to group professional autonomy, is nevertheless constrained by tortious interference principles because it invades individual clinical discretion. Fee splitting laws have also been applied to both individual and, to a lesser extent, to group incentives. When the institution turns to organizational structure, it continues to face the same two lines of defense. The law gives detailed scrutiny to the grounds for individual medical staff discipline administered by fellow physicians, and it insulates this process from hospital overhaul by mandating medical staff independence and self-governance.

B. Critique of Physician Autonomy

To a large extent, this preservation of professional autonomy is unjustified. Unquestionably, sound medical practice requires a degree of restriction on interference with the details of medical treatment, whether from a lay or professional source. The scientific foundations of medicine justify some group autonomy and its judgmental nature justifies some individual autonomy. It is wrong, however, to insist on absolute freedom from control. When the unknown value of medical procedures leaves a broad range of acceptable methods of patient management and medical practice—the current situation with the great bulk of medicine—it is difficult to maintain that influencing physicians to exercise their judgment conservatively is inappropriate.³⁸⁵ To the extent that restrictions on institutional influence lack a strong quality-of-care justification, they serve primarily to protect the vested interests of physicians.

Astonishingly, physicians have demonstrated continuing success in convincing legislatures to extend further these protections despite a fundamental reorientation in health care policy. The federal government has equivocated on institutional control by banning hospital attempts to pass prospective payment incentives on to physicians and by excluding efficiency considerations from its protection of peer review. Congress'

³⁸⁵ See E. FREIDSON, *supra* note 48, at 182-83.

Much of what is called patient management . . . is not sustained or chosen by any systematic scientific knowledge, but rather by personal preference and experience and by occupational custom and folklore. As management, hospital administration should be prepared to take issue with medical dominance over that portion of medical work that influences the well-being and satisfaction of patients without at the same time having a technical or scientific rationale.

Id.; see also P. STARR, *supra* note 30, at 5 (distinguishing between the technical aspects of medical practice and its socio-economic effects).

As further justification for restricting professional dominance of medical practice, Freidson argues:

But even if there were a science of administration or teaching, or consulting, or whatever is involved in applying knowledge, the autonomy of practice would still not be justified owing to the fact that, apart from what is purely technical and instrumental about practice, there is embodied in it an ineradicable moral element. . . . These considerations of the moral consequences of the social choices which are inherent in the process of applying knowledge are not merely technical and cannot justifiably be determined by experts alone. Thus, I argue, professional autonomy in determining the content of all of its work is not justified: autonomy in developing the knowledge embodied in the content of work may be appropriate, but autonomy in determining the practical modes of applying that knowledge is not.

E. FREIDSON, *supra* note 30, at 357-58.

deep seated ambivalence about the need to restrict services has helped to undermine current cost containment policy.

By this critique, I do not mean to accuse physicians or lawmakers of calculated manipulation of the law to pursue evil ends. I mean only to register the undeniable fact that the law acts as a force against reform because it is naturally contoured to fit the shape of traditional medical relationships. The connection between the law and physicians' interests is an organic one, not a conspiratorial one.³⁸⁶

Nevertheless, the blunt fact remains that our health care cost containment policy is doomed to failure, or at least to mediocrity, in the current legal environment. Physicians, who have shown extraordinary resistance to change in the past,³⁸⁷ will use every weapon in their considerable arsenal to defend against the onslaught of new economic and social forces. Already, leaders in the profession are sounding the alarm that "physicians must either gain control . . . or work for those who do control"³⁸⁸ Although physicians are now prohibited from using their code of ethics to block economic reform, the prognosis for cost containment remains poor in view of the broad range of legal doctrines that provide physicians with ample protection from institutional influence. In short, the new reimbursement policy cannot survive in a legal climate so fundamentally infused with a professional libertarian credo.

³⁸⁶ In the words of Eliot Freidson:

Both professional and bureaucrat have, by and large, the best of intentions. Both, like everyone else, are creatures of their perspectives, and those perspectives are limited by training, by commitment, and by personal work experience that comes to be regarded as wisdom.

E. FREIDSON, *supra* note 48, at 158.

³⁸⁷ See Havighurst, *supra* note 53, at 307 ("[P]hysicians now respond almost reflexively to outside interference in their affairs"); Law & Ensminger, *supra* note 53, at 55 ("[D]octors tend to characterize *any* effort to constrain physicians' income or to use social power to encourage physicians to work in ways that best meet social needs as 'slavery' or 'socialism.'").

³⁸⁸ Kralewski, Dowd, Feldman & Shapiro, *The Physician Rebellion*, 316 NEW ENG. J. MED. 339, 342 (1987); see also Hellinger, *Perspectives on Enthoven's Consumer Choice Health Plan*, 19 INQUIRY 199, 204 (1982) ("[W]e should expect a strong effort on the part of organized medicine to maintain the individual practice, fee-for-service practice of medicine that has dominated the profession"); Kralewski, Dowd, Feldman & Shapiro, *supra*, at 339 ("Physicians are becoming increasingly concerned about the controls being placed on their practices by [HMOs], preferred-provider organizations, third-party insurance plans, and in some cases, their own group practices"); Johnson, *Doctors' Dilemma: Unionizing*, N.Y. Times, July 13, 1987, at D1, col. 1 (doctors are rebelling against HMO controls by threatening to unionize); Hull, *Physicians Organize to Stop HMOs From Altering Practice of Medicine*, Wall St. J., June 23, 1986, at 23, col. 4 ("Doctors across the country are beginning to organize a fight against the changes health-maintenance organizations are bringing to medicine.").