Corporate Medicine in 21st Century Health Care

This article first appeared in the June 2007 edition of Physician’s News Digest.

The corporate practice of medicine doctrine was created by the American Medical Association (AMA) to protect the public as well as the profession of medical doctors. The doctrine essentially bans unlicensed individuals and entities from engaging in the practice of medicine by restricting them from employing licensed physicians. The intent of the doctrine was to ensure that only licensed professionals delivered medical care and that lay persons and entities not influence treatment decisions. The premise underlying the doctrine was that it would protect patients from potential abuses because commercialized medicine ultimately would divide a physician’s loyalty between profits and the delivery of quality patient care.

Lobbying by the AMA, together with its pronouncements concerning corporate medicine, had a profound effect on state legislation. States began licensing medical doctors in order to regulate the sources of medical care for patients, as well as to establish them as the sole professionals for rendering such care. This resulted in limiting the practice of medicine to licensed medical doctors.

Under state law, the corporate practice of medicine typically manifests itself through the prohibition on non-licensed persons or corporations from employing physicians to practice medicine, restricting the delivery of

Can You Pass A Health Care Good Governance Test?

This article first appeared in the July 9, 2007 edition of the Health Care Law Supplement of The Legal Intelligencer/ Pennsylvania Law Weekly.

If you are a board member, officer, owner, member of the management team, executive or in any way responsible for the governance of a health care organization in today’s fast-changing environment, can you answer the questions raised in a modern governance test? In particular, if you are a fiduciary of a nonprofit health care organization, can you answer the additional challenging questions that apply to those entities?

How do individuals learn and understand the appropriate rules of governance when they are responsible for organizations that save lives, care for patients in an institutional setting, research new treatments and pharmaceuticals, and deliver drugs, equipment and specialized treatment to patients every day?

These issues are pervasive throughout health care organizations and across state boundaries. Each organization needs to determine what level of knowledge, education and training is appropriate for its governance team, as there is no one treatment applicable to all.

Those board members who are newly elected to New Jersey hospitals should take special note of their responsibilities for training. A newly enacted legislative initiative (signed by acting Governor Codey on April 30, 2007) addresses financial, organizational, legal, regulatory and ethical issues that board members must understand to properly serve as directors of New Jersey hospitals.

The Basic Concepts

While state and federal laws differ on the fiduciary standards applicable to organizations, there is a
medical services to those entities owned and controlled only by licensed professionals, and prohibiting the division or splitting of professional fees between licensed medical doctors and non-licensed individuals or entities.

Similar to many jurisdictions, there is no single source of law in the Commonwealth of Pennsylvania that prohibits corporate entities from employing physicians or rendering professional medical services. The doctrine has, however, come to be regarded as having legal force and is derived from several sources of law, including the Medical Practice Act of 1985, the Business Corporation Law of 1988, the partnership laws, the Limited Liability Company Law of 1994 and the Health Care Facilities Act.

The unauthorized practice of medicine is codified under the Medical Practice Act of 1985. The Medical Practice Act provides: “no person other than a medical doctor shall engage in the practice of medicine or surgery, purport to practice medicine or surgery, hold forth as authorized to practice medicine and surgery through use of a title, including, but not necessarily limited to, medical doctor, doctor of medicine, doctor of medicine and surgery, doctor of a designated disease, physician, physician of a designated disease, or any abbreviation of the foregoing, or otherwise hold forth as authorized to practice medicine and surgery.”

Violation of the Medical Practice Act can result in fines and penalties, including imprisonment.

The seminal case in Pennsylvania supporting the prohibition on the corporate practice of medicine is Neill v. Gimbel Brothers, Inc. (1938). In Neill, the Pennsylvania Supreme Court ruled that a corporation is prohibited from engaging in the practice of optometry and may not employ optometrists for the rendering of such services to the public. Consistent with the premise underlying the doctrine, the Court reasoned: “A corporation as such cannot possess the personal qualities required of a practitioner of a profession. Its servants, though professionally trained and duly licensed to practice, owe their primary allegiance and obedience to their employer rather than to the clients or patients of their employer. The rule stated recognizes the necessity of immediate and unbroken relationship between a professional man and those who engage his services.”

There are a few exceptions to the doctrine in Pennsylvania, including practicing medicine through a professional corporation, limited liability partnership, or restricted professional company. Specifically, under Pennsylvania law, only licensed physicians may be shareholders of or partners or members in, as the case may be, professional corporations, limited liability partnerships or restricted professional companies that have been formed to provide medical services. The statutes require that all of the ultimate beneficial owners of these entities be licensed persons. In fact, the legislative intent of each of these laws is to authorize only licensed persons to render professional services through these types of entities. Pennsylvania also permits health maintenance organizations, and licensed hospitals and health care facilities to employ physicians and provide health care services.

Although enforced in several jurisdictions, at issue is whether the doctrine is relevant in today’s health care environment, given the advancements in technology, the advent of complex health care networks and current reimbursement structures. Specifically, the delivery of health care has shifted from a fee-for-service system, where a physicians’ clinical judgment remained unquestioned and patients retained freedom of choice, to a system focused on care management, cost-containment, physician accountability and minimal patient choice. As long as managed care organizations and other commercial payors continue to dominate the marketplace, commercial entities will influence health care delivery. In some cases, the doctrine simply has become obstructive to an efficient and quality driven health care system with little or no benefit.

Over 30 years ago, the Federal Trade Commission (FTC) acknowledged the doctrine’s restriction on competition. The FTC has taken the position that the doctrine can hinder development of innovative health care delivery systems that may be more cost-effective and quality-driven. In fact, in its studies, the FTC has found that the doctrine creates higher prices without necessarily a corresponding increase in quality. Accordingly, the FTC
has encouraged legislatures and state regulators to repeal or modify corporate practice restrictions. Florida represents a jurisdiction that permits such practice, provided certain safeguards are implemented.

In an age that has seen the demise of indemnity plans and the rise of for-profit health care systems, risk-sharing arrangements and managed care utilization review organizations, the question is whether the corporate practice of medicine doctrine has become unworkable. Too often, physicians who desire needed capital are prevented from partnering with non-licensed individuals or entities. Individuals and entities that may be better positioned to finance costly technology, which ultimately could improve patient care, may be locked-out of the market. Today, physicians are quite conscious of the amount of time they spend with patients and are certainly influenced by financial outcomes. The passage of Stark underscores this fact.

Accordingly, states need to reevaluate the applicability and benefits (if any) of the prohibition on the corporate practice of medicine and recognize that in order to truly move toward a health care system that encourages technological advancement, improved patient care, and cost-efficiencies, corporate medicine not only has a place in the system, but ultimately could benefit such a system.

Author:
John W. Jones, Jr.
215.981.4706
jonesj@pepperlaw.com

Test, continued from page 3
certain fundamental standard to which all boards and management must adhere in the area of governance. That is the “business judgment” or “prudent man” standard.

The standard typically means that directors should act “on an informed basis in the best interests of the company with no evidence of bad faith or self-dealing.”

For nonprofit board members, the standard may be higher, due to what courts have considered the added burden of protecting charitable assets.

In general, boards of directors have great latitude in carrying out the business judgment rule in business corporations and public companies. Courts have allowed the markets and market value to decide whether boards have taken proper action, rather than imposing their views over those of corporate management.

In nonprofits, where the state attorney general typically has the last word on whether the nonprofit board members took appropriate action, there is less of a tendency to give such wide discretion for bad business decisions or those that may be tainted by bad faith or conflicts of interest.

In health care generally, the board has a higher duty than a board of a company such as Disney, simply because the health care organization is not dealing just with money, but with lives of patients and the special relationship the health care organization has in the community and with its patients, physicians and employees.

Governance Decisions

Let’s imagine that you are a board member of an organization faced by one or more of the following. How would you handle the situation?

- An academic institution receives a research grant that leads to a product that can be successfully developed commercially. The institution has a brand name nationally. The management of the institution decides to lend the name of the institution to the product marketing and promotion. What independent voice will determine whether to proceed with the use of the name of the organization in product marketing, and who monitors these arrangements to ensure that the institution is protected in seeking the new revenue sources? Should the board of directors have a say in what happens, especially when the institution’s name and overall reputation is at stake?
• A hospital is involved in a transplant program. After an internal investigation, it is revealed that dozens of patients have died awaiting organs for transplant, due to overall mismanagement by the clinical heads, a lack of strategic direction and the failure to adhere to quality assurance standards. Who has oversight in this situation over physician staffing levels, clinical competency and quality measures? Should the board of directors have responsibility for patient safety and outcomes? Do such failures go to the heart of the mission of the institution when patients lose their lives needlessly?

• The CEO of a hospital also happens to be a personal investor in a venture fund. The venture fund owns an interest in a company that manufactures a device that is used at the hospital. Who is responsible for monitoring the disclosure of such a relationship and overseeing the balance between patient care, private industry, academics and research?

• A management team is recruited with a seemingly lucrative compensation package. The compensation is not established initially nor in subsequent years by any outside compensation specialist. When the compensation becomes public, many board members disclose that they had no knowledge of the compensation being paid nor of the procedure followed by the board in setting the compensation. Who has the responsibility for setting executive compensation, and, especially in a nonprofit organization, who has the oversight to avoid the penalties that can be assessed by the IRS and others if personal benefits are received without review?

• The IRS sends your health care organization a post-issuance compliance survey relating to a recent tax-exempt bond issue. The questionnaire asks for responses about record-keeping requirements and adherence to IRS standards relating to the use of bond proceeds for the construction of facilities and the investment of reserve funds. As it turns out, the CFO never understood many of the terms of the debt documents and, due to his workload, never complied with many of the deadlines and filings he was supposed to make in connection with the financing. Who is responsible for overseeing the debt issuance process and the multitude of requirements and covenants in those complex transactions?

Organizations therefore should create a code of ethics that establishes an overall environment for board members, officers, management and other employees to be guided by when confronted with a difficult set of choices.

Governance Toolkit

There are reasonable steps that a board of directors, a management committee or an oversight committee should take in order to be prepared to respond to the challenging situations that will fairly regularly confront a health care organization – be it one that is actively caring for patients, researching new approaches to patient treatment and care, or developing new products, equipment and processes.

As the above examples demonstrate, there will be many situations that do not fit neatly into a solution box. Organizations therefore should create a code of ethics that establishes an overall environment for board members, officers, management and other employees to be guided by when confronted with a difficult set of choices.

Once the overall tone of ethical behavior is established, it allows other policies that address particular areas of concern to flourish – such as policies on billing compliance, no-gifts, charity-care and non-discrimination. For many organizations, whether they are public companies or nonprofits, a code of ethics provides a signal to the public that ethics plays an important role in the delivery of services.

Ensure that patient safety committees or clinical oversight committees have representation from the governing body. Boards and executive management have a responsibility to know that the care being provided or the treatments being developed are safe for patients.

It is no longer acceptable to delegate those responsibilities entirely to others. Involvement of non-clinicians in the oversight of patient safety can help avoid problems that might otherwise arise if data had not been monitored or tough questions about outcomes had not been asked by those with independent judgment. Independent judgment
can help to avoid catastrophe, whether the issue concerns unexplained deaths in a transplant program or an unusual level of hospital-acquired infections. Such oversight also can help determine whether the cause of a problem is a lack of resources or staffing.

Institute initial and continuing education programs for governing boards and management – they are essential to the success of any organization and the safety of the public being served.

New Jersey has codified the education requirement for new board members of hospitals in its state, taking a leadership position in this important issue. A curriculum to be developed by New Jersey’s Secretary of the Department of Health and Human Services, together with the hospital industry associations, will create a training regimen that will include a review of the financial, organizational, legal, regulatory and ethical issues facing hospitals and their governing bodies.

Areas likely to be addressed in the training include:
- reimbursement and payment systems
- nonprofit tax-exempt issues, including those arising from bond financings
- the importance of audit committees and their role in overseeing financial and risk areas within an organization
- patient safety issues, including those arising from infections, credentialing of physicians and the development of best practices
- trends in the health care industry, including changes brought by the increasing number of outpatient procedures
- the rise of imaging technologies and electronic medical records, and the potential positive impact of e-prescribing and electronic order-entry
- new approaches to responding to claims of medical malpractice and arbitration, admission of wrong-doing and guarantees of patient care.

Take steps to comply with all current concerns and interests of the IRS, if your organization operates as
a 501(c)(3) charity. Congress and the IRS have been highlighting their concerns through hearings and pronouncements alerting providers to problems they have been observing.

Nonprofits should:

• stay true to their organization’s charitable mission by avoiding questionable behavior for 501(c)(3) health care organizations
• tighten up conflict of interest policies
• provide more detailed information on IRS Form 990 (Return of Organization Exempt from Income Tax)
• include a code of ethics and a commitment to compliance in all publications and on all Web sites
• report compensation and benefits paid to current and former board members and employees.

Review all current and future directors and officers liability insurance policies. Due to the number of problems uncovered since the enactment of Sarbanes-Oxley legislation applicable to public companies, D&O coverage has been tightened. As a result, the comfort many directors and officers felt has been greatly diminished under such policies.

In order to recruit and retain the best possible outside board and governance members, it would be prudent to review and negotiate the D&O policies to obtain the best possible terms, depending upon cost and market availability. Directors and officers should avoid sharing the pool of protection with the entity itself, minimizing large retentions for board members and paying legal fees from the insurance available, as doing so could dilute the protection expected by board members and expose them to liability that was never intended.

What To Do Next?

Rather than deal with issues in the abstract, all governing boards, management and those with an interest in their organizations should meet in a retreat on a regular basis, at least once a year, to review the top issues in potential and real exposure they saw in the past year. No doubt, with all of the activity in any health care organization in any given year, there will be plenty of examples to review and digest.

Then, in a non-threatening and legally privileged environment, boards and management should recommend policies and procedures for handling such situations better in the future.

It is essential that the governing body be a part of the solution, as a “head-in-the-sand” approach will not help the health care organization correct its deficiencies and thrive.

Author:

Henry C. Fader
215.981.4640
faderh@pepperlaw.com