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Recommended Citation
Lisa R. Hayward, Notes and Comments, Revising Washington's Corporate Practice of Medicine Doctrine, 71 Wash. L. Rev. 403 (1996). Available at: https://digitalcommons.law.uw.edu/wlr/vol71/iss2/4

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REVISING WASHINGTON'S CORPORATE PRACTICE OF MEDICINE DOCTRINE

Lisa Rediger Hayward

Abstract: Current Washington law prohibits the corporate practice of medicine. The courts have interpreted this doctrine to prohibit the employment of physicians by any entity, other than a professional corporation or health maintenance organization, even if the corporation only performs business functions. This Comment discusses the corporate practice of medicine doctrine in Washington and its usefulness in the modern health care environment. It argues that two of the doctrine's underlying justifications are effectuated more sensibly by current regulatory provisions and that the doctrine should be retained only to prevent lay interference with physician autonomy in medical decisions. This Comment recommends that the Legislature amend the Medical Practice Act to clarify the scope of the doctrine and minimize its harmful effects.

Suppose Dr. Smith, Dr. Jones, and Nurse Brown incorporate to form a clinic to provide medical services to indigent persons in Seattle, Washington. All three individuals are licensed in their respective professions and have exceptional records for providing superior quality care. The clinic operates successfully for some time; it earns its reputation as an excellent source of care. However, a jealous competitor brings suit against the clinic to drive it out of business. The ground for suit: the clinic violates the corporate practice of medicine ban. The outcome: Dr. Smith, Dr. Jones, and Nurse Brown lose their licenses to practice and the clinic is permanently enjoined from "practicing medicine."

The above scenario illustrates the corporate practice of medicine doctrine which operates in virtually all states, including Washington, to prohibit corporations from engaging in the practice of medicine. Courts have interpreted the doctrine to bar most corporations from employing physicians because a corporation practices medicine through its

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employees. A corporation that practices medicine engages in the unlicensed practice of medicine, subjecting it to both criminal and civil liability.

Nevertheless, corporations have furnished medical services for many years. Corporations contracted with mining and lumber companies to provide medical services in Washington as early as 1900. In recent years an increasing number of corporations have entered the health care field. The proliferation of health maintenance organizations (HMOs), preferred provider organizations (PPOs), management service organizations (MSOs), and independent practice associations (IPAs) exemplifies the increased incorporation of medicine. Furthermore, integrated delivery systems (IDSs) are the newest trend in health care delivery. New and varied organizational creatures will continue to emerge in the health care marketplace as long as concerns over the cost and efficiency of providing medical services predominate.

The corporate practice of medicine doctrine developed in the first half of this century to protect consumers from receiving substandard care at the hands of medical professionals hired by nonphysicians. However, the health care environment has changed considerably since the doctrine was established. Regrettably, the corporate practice of medicine laws have failed to keep pace with the rapidly changing health care

2. Most courts have not distinguished between the actual practice of medicine and furnishing medical services through licensed professionals. See, e.g., People v. United Med. Serv., Inc., 200 N.E. 157 (III. 1936); Parker v. Board of Dental Examiners, 14 P.2d 67 (Cal. 1932).
4. Physician-hospital organizations (PHOs) have entered the market at a rapid pace. At the end of 1994, more than three-quarters of the estimated 500 PHOs were less than two years old, and about half were less than one year old. See Physician Payment Review Commission, 1995 Annual Report to Congress 245.
6. An integrated delivery system is an organization that furnishes patients with all levels and types of health care services from affiliated providers. Id. at 274.
7. Beth Melville, Hospitals Moving to Integrated Delivery Systems Facing Physician Resistance, 6 Managed Care Outlook (1993) available in Westlaw, MCAREOUTLK Database, 1993 WL 2822813 (citing recent survey indicating that 56.5% of hospitals, 76.8% of multiple hospital systems, and 45.2% of medical group practices have an integrated delivery system or plan to have one in the next year).
9. Id. at 478.
environment. The trend is clearly moving toward more integrated delivery systems, yet many of these organizations violate the fundamental terms of the corporate practice of medicine doctrine.

Although the doctrine has existed for over fifty years, courts in Washington have not considered it for some time.\textsuperscript{10} New organizations essentially are gambling that the doctrine will remain dormant. Recently, however, the doctrine has experienced a resurgence in other states.\textsuperscript{11} It is plausible that Washington could revive the doctrine as well. The application of the corporate practice of medicine doctrine has the potential to affect thousands of physician relationships in the state. The growing movement toward managed care and integrated delivery systems underscores the importance of resolving the status of the doctrine in Washington. Furthermore, health care providers and their attorneys need to be certain about what types of physician-health care provider arrangements are lawful.

This Comment discusses the corporate practice of medicine doctrine in Washington and argues that the Legislature should define its scope to severely limit its application. Part I describes the evolution of the doctrine nationwide and in Washington. It sets forth the justifications for the doctrine's development and outlines the exceptions and the sanctions for violation. Part II examines the current status of the doctrine and discusses how the doctrine's scope has been extended over time. Part III argues that the corporate practice of medicine laws have not kept pace with the changing health care environment and do not reflect the current legislative acquiescence to corporate-physician relationships. Finally, part IV suggests that the Washington Legislature should adopt an amended definition of the practice of medicine using a South Dakota statute as a model.

\textsuperscript{10} The most recent decision involving the doctrine in Washington occurred in 1988. See Morelli v. Ehsan, 110 Wash. 2d 555, 756 P.2d 129 (1988), infra part II.B.

I. THE DEVELOPMENT OF THE CORPORATE PRACTICE OF MEDICINE DOCTRINE

A. Rationale Behind the Doctrine

The rule prohibiting the corporate practice of medicine originates in part from state professional licensure requirements. 12 State medical licensure acts forbid and provide sanctions against the practice of medicine by unlicensed persons. 13 Only a person can undergo the training, examination, and character-screening that are prerequisites to professional licensure. 14 Thus, as impersonal entities, corporations are unable to meet these statutory requirements and cannot practice medicine. 15

The doctrine also evolved to protect the public from “quackery” and possible abuses stemming from the commercial exploitation of the practice of medicine. 16 The public policy justifications for the doctrine include assumptions that: (1) corporate involvement in medical practice creates a potential for divided physician loyalty between the corporation and the patient; 17 (2) a lay person should not have control over medical decision-making; 18 (3) a corporation lacks the ability to establish and maintain the trust requisite to the physician/patient relationship; 19

15. For many purposes, a corporation is treated as if it were a person. The edification of a corporation to the status of a person is one of the most widely accepted legal fictions. The word “person” as used in a statute will generally be construed to include corporations, as long as such an interpretation fits within the general design and intent of the act. See Sanford A. Schane, The Corporation Is a Person: The Language of a Legal Fiction, 61 Tul. L. Rev. 563 (1987). However, courts have interpreted the term “person” in the context of medical licensing statutes to include only human-beings. See e.g., Dr. Allison, Dentist, Inc. v. Allison, 196 N.E. 799, 800 (Ill. 1935) (“To practice a profession requires something more . . . . It can be done only by a duly qualified human being . . . . The qualifications include personal characteristics . . . . No corporation can qualify.”).
17. State Bd. of Optometry v. Gilmore, 3 So. 2d 708, 709 (Fla. 1941); Dr. Allison, 196 N.E. at 800 (stating that doctors who were hired by corporations would owe their first allegiance to the corporation and “cannot give the patient anything better than a secondary or divided loyalty”).
19. Silver v. Lansburgh & Bros., 111 F.2d 518, 520 (D.C. Cir. 1940); Dr. Allison, 196 N.E. at 800.
(4) a corporation may concern itself more with profit levels than with the patients' quality of care or personal well-being.20

B. Early Application of the Doctrine

1. Case Law Establishes the Doctrine

One of the earliest applications of the doctrine was in 1932, in Parker v. Board of Dental Examiners.21 Parker, a dentist, formed a corporation for the purpose of owning and operating dental offices. The California Supreme Court rejected Parker's argument that the actual practice of dentistry should be distinguished from the purely business aspects of the practice.22 Instead, the court upheld a finding that Parker had aided and abetted an unlicensed person (the corporation)23 in the unlawful practice of dentistry.24

People ex rel. State Board of Medical Examiners v. Pacific Health Corp.25 extended the doctrine to prohibit a corporation from contracting with persons to pay for potential medical services in exchange for payment of premiums. The corporation in that case paid for medical services only if a person received treatment from a physician approved by the corporation.26 The California Supreme Court held that this arrangement violated the corporate practice doctrine.27 Pacific Health argued unsuccessfully that the physicians were independent contractors, not employees, because they were paid for actual services rendered rather than compensated on a salary basis. The corporation also argued that the physicians were not subject to corporate control. The court said that it would not allow "technical distinctions" to circumvent the policy of the


22. Id. at 71–72.

23. In this context, the court interpreted the word "person" to include a corporate entity. See generally Schane, supra note 15 (examining the philosophical background, constitutional controversies, and the linguistic basis of treating the corporation as a person).

24. Parker, 14 P.2d at 73.


26. Id. at 429. The contractual arrangement proposed in Board. of Med. Examiners resembles a preferred provider organization (PPO). See supra note 4 (discussing the operation of PPOs throughout the United States).

27. Id. at 430.
law and added that "the evils of divided loyalty" would be present whether physician benefits were from salary or fees.\textsuperscript{28}

These two decisions and others\textsuperscript{29} firmly established the corporate practice of medicine doctrine, and it became the nationwide majority rule. Eventually, all states but Nebraska adopted the doctrine.\textsuperscript{30} Courts and state officials rigorously enforced the corporate ban throughout the first half of this century.\textsuperscript{31}

2. Washington Adopts the Doctrine

The Washington Supreme Court first recognized the corporate practice of medicine doctrine in 1943 in \textit{State ex rel. Standard Optical Co. v. Superior Court}.\textsuperscript{32} The case involved a proceeding in the nature of quo warranto\textsuperscript{33} against the defendant corporation, charging it with unlawfully practicing optometry.\textsuperscript{34} Standard Optical operated a store which was in the sole charge of a licensed optometrist.\textsuperscript{35} The corporation employed the optometrist and paid him a salary plus a commission based upon the gross receipts.\textsuperscript{36} Standard Optical purported to exert no control over the optometrist's professional judgment.\textsuperscript{37} The supreme court held that optometry was a profession that only persons, not corporations, could practice. Accordingly, the court found the defendant corporation guilty of practicing optometry within the state.\textsuperscript{38} The court declared that whether the "optometrist in his practice exercised his professional judgment conscientiously in each individual case, [had] no bearing upon

\begin{verbatim}
28. Id.
29. The Illinois Supreme Court in \textit{People v. United Medical Serv., Inc.}, for example, interpreted the language of the state's medical practice act to prevent a corporation from providing medical services through its clinic and rejected the argument that owning a corporation that employs licensed physicians and collects patient fees does not constitute practicing medicine. 200 N.E. 157 (Ill. 1936).
31. Id. at 475–84.
32. 17 Wash. 2d 323, 135 P.2d 839 (1943).
33. A writ used in the law of corporations to test whether a corporation is validly organized or whether it has the power to engage in the business in which it is involved. \textit{Black's Law Dictionary} 868 (6th. ed. 1991).
34. Standard Optical, 17 Wash. 2d at 324, 135 P.2d at 840.
35. Id. at 326, 135 P.2d at 840.
36. Id.
37. Id.
38. Id. at 331, 135 P.2d at 842–43.
\end{verbatim}
the questions here presented."\textsuperscript{39} The court also characterized the employment contract as a "[device] to avoid the provisions of our statutes."\textsuperscript{40}

In arriving at its holding in \textit{Standard Optical}, the court relied on the nationwide majority rule against the corporate practice of medicine.\textsuperscript{41} The court also articulated the evils it wished to avoid. Specifically, it noted that corporations might practice medicine or dentistry by employing licensed agents which would destroy professional standards, and that professions would be commercialized to the public detriment.\textsuperscript{42} The court explained that professional ethics are based upon personal responsibility to a patient, and therefore, a professional cannot act properly if he is "an agent of a corporation or business partnership whose interests . . . are commercial in character."\textsuperscript{43}

The Washington Supreme Court next applied the doctrine in \textit{State v. Boren}.\textsuperscript{44} The defendants, Boren and Shepherd, formed a partnership to own, maintain, and operate dental offices. Neither Boren nor Shepherd had ever been licensed to practice dentistry in Washington. The partnership entered into a conditional sales contract with Harlow, a licensed dentist, to sell its Seattle office.\textsuperscript{45} Boren managed the office as a part of the deal, and his duties included purchasing supplies, handling the accounts and payments, and advertising the practice.\textsuperscript{46} The court reiterated the holding from \textit{Standard Optical} that an unlicensed person or entity may not engage in the practice of medicine, surgery, or dentistry through licensed employees.\textsuperscript{47} To reach the conclusion that the partners were unlawfully practicing dentistry, the court relied on a statute that defined the practice of dentistry to include a person "who owns, maintains or operates an office for the practice of dentistry."\textsuperscript{48}

\begin{itemize}
\item \textsuperscript{39} \textit{Id.} at 334, 135 P.2d at 844.
\item \textsuperscript{40} \textit{Id.} at 331, 135 P.2d at 842.
\item \textsuperscript{41} The majority rule is that "a corporation cannot engage in the practice of medicine, and that neither a corporation nor any other unlicensed person or entity may engage, through licensed employees, in the practice of medicine or surgery." \textit{Id.} at 329, 135 P.2d at 841.
\item \textsuperscript{42} \textit{Id.} at 331–32, 135 P.2d at 842 (citing \textit{Ezell v. Ritholz}, 198 S.E. 419, 424 (S.C. 1938)).
\item \textsuperscript{43} \textit{Id.} (quoting \textit{Ezell}, 198 S.E. at 424).
\item \textsuperscript{44} 36 Wash. 2d 522, 219 P.2d 566, \textit{appeal dismissed per curiam}, 340 U.S. 881 (1950).
\item \textsuperscript{45} \textit{Id.} at 523, 219 P.2d at 567.
\item \textsuperscript{46} \textit{Id.} at 524, 219 P.2d at 567.
\item \textsuperscript{47} \textit{Id.} at 531, 219 P.2d at 572.
\item \textsuperscript{48} \textit{Id.} at 525–26, 219 P.2d at 568 (quoting Rem. Rev. Stat. § 10031(6)).
\end{itemize}
C. Exceptions and Limitations to the Doctrine

State court decisions and legislative acts have carved out exceptions to the general rule against the corporate practice of medicine. Thus, the application and scope of the doctrine varies among the states.

1. Nonprofit Organizations

Some states distinguish between not-for-profit and for-profit corporations and refuse to apply the doctrine to nonprofit organizations. The rationale that courts generally give for excluding nonprofit organizations is that the policy concerns underlying the doctrine largely are vitiated when the profit motive is removed. For example, courts commonly announce that concerns of commercial exploitation, divided physician loyalty, and lay control of physicians justify the corporate prohibition. But because these principal evils spring from the conflict between the professional and the profit motive of the corporation, they do not apply to nonprofit organizations.

The Washington courts and Legislature have never accepted this distinction between for-profit and nonprofit organizations. Every Washington case that applied the doctrine, however, involved for-profit organizations. Thus, it is unclear whether Washington courts would recognize the nonprofit exception, if presented with an appropriate case.

2. Professional Corporations

All states have limited the scope of the corporate practice of medicine doctrine by adopting statutes which authorize licensed professionals to


50. Board of Medical Examiners, 82 P.2d at 431 (stating that "the objections of policy do not apply to nonprofit institutions"). See generally 6770 Op. Mich. Att'y Gen. (1993) (reviewing legal authority from many states regarding the propriety of nonprofit hospitals employing physicians and concluding that the corporate practice prohibition does not apply to nonprofit corporations).

51. See supra text accompanying notes 17-20.

52. See Board of Medical Examiners, 82 P.2d at 431; see also Henry B. Hensmann, Reforming Nonprofit Corporation Law, 129 U. Pa. L. Rev. 497, 539 (1981).

form professional corporations to engage in the practice of medicine.\textsuperscript{54} However, these statutes usually require that all shareholders and officers of the corporation be licensed professionals.\textsuperscript{55}

In Washington, the Legislature enacted the Professional Service Corporations Act in 1969.\textsuperscript{56} The Act authorizes licensed physicians to organize a corporation to provide medical services.\textsuperscript{57} The Act creates a very narrow exception to the corporate practice of medicine prohibition because only individuals who hold the same professional license either can join in the formation of a given professional service corporation or become shareholders therein at any time after its formation.\textsuperscript{58}

3. Health Maintenance Organizations

State legislatures have also provided an exception to the doctrine for health maintenance organizations that employ physicians to practice medicine. HMO development became a federal priority in the early 1970s as a mechanism to curb rising health care costs.\textsuperscript{59} However, state laws prohibiting the corporate practice of medicine posed a significant obstacle to HMO growth. In response to this problem, numerous states adopted legislation that expressly exempted application of the corporate practice doctrine to provider relationships with HMOs.\textsuperscript{60}

The Washington Legislature amended the Professional Service Corporations Act in 1983 to produce an HMO exception. The


\textsuperscript{56} Wash. Rev. Code § 18.100.050.

\textsuperscript{57} The Act defines a professional corporation as "a corporation which is organized . . . for the purpose of rendering professional service." Wash. Rev. Code § 18.100.030(2) (1994). The Act further provides that "[n]o corporation organized under this chapter may render professional services except through individuals who are duly licensed or otherwise legally authorized to render such professional services within this state." Wash. Rev. Code § 18.100.060 (1994).

\textsuperscript{58} Wash. Rev. Code § 18.100.050. This provision, thus, would not exempt the hypothetical Smith-Jones-Brown clinic.


amendment provides that "licensed health care professionals, providing services to enrolled participants either directly or through arrangements with a health maintenance organization . . . may own stock in and render their individual professional services through one professional service corporation." Thus, the so-called HMO exception authorizes physicians and other non-professional individuals to incorporate in an HMO setting. Although the legislative history of this amendment reveals little as to the impetus for the amendment, the nationwide trend and pressure from the increasing employment of physicians by HMOs such as Group Health Cooperative of Puget Sound most likely contributed to its adoption.  

D. **Penalties for Violating the Corporate Practice of Medicine Doctrine**

Few states expressly prohibit the corporate practice of medicine. As a result, penalties generally are imposed for the unlicensed practice of medicine. Most states consider it a criminal offense for any person or entity to practice or attempt to practice medicine without a valid license.

Section 18.71.011 of the Revised Code of Washington defines the practice of medicine, and section 18.71.021 requires that an individual possess a valid license in order to practice medicine. Thus, a

64. See Dowell, supra note 16.
66. The statute provides:
A person is practicing medicine if he . . .
(1) [o]ffers or undertakes to diagnose, cure, advise or prescribe for any human disease, ailment, injury . . . or other condition, physical or mental, real or imaginary, by any means or instrumentality;
(2) [a]dministers or prescribes drugs . . . to be used by any other person;
(3) [s]evers or penetrates the tissues of human beings;
(4) [u]ses on cards, books, papers . . . giving information to the public . . . the designation "doctor of medicine", "physician", "surgeon", "m.d." or any combination thereof.
corporation—excluding a professional service corporation or HMO—that practices medicine engages in the unlicensed practice of medicine because only individuals are eligible for licenses.68

The Secretary of Health is responsible for investigating complaints concerning the unlicensed practice of medicine in Washington and has the authority to issue a temporary or permanent cease and desist order, which may include a civil fine.69 In addition, the Attorney General, a county prosecuting attorney, or any person may maintain an action in the name of the state to enjoin the unlicensed practice of medicine.70 The injunctive remedy is in addition to any criminal liability.71 The unlicensed practice of medicine constitutes a gross misdemeanor for a single violation, and each subsequent violation is a class C felony.72

II. CURRENT STATUS OF THE CORPORATE PRACTICE OF MEDICINE DOCTRINE

The influence and effects of the corporate practice of medicine doctrine have waned considerably in modern times.73 In recent years, all but a handful of states have generally ignored the doctrine.74 At last count, five states were enforcing the doctrine, twenty-six states (including Washington) were either neglecting the doctrine or were ambiguous about its application, and nineteen states were ignoring or had

68. Wash. Rev. Code § 18.71.021 ("No person may practice medicine . . . without first having a valid license to do so.") (emphasis added). Courts have consistently interpreted the word "person" in medical licensure statutes to include only human-beings and not corporations. See supra note 15.


70. Wash. Rev. Code § 18.130.190(6) (Supp. 1995). Previous Washington case law established a physician's right to seek injunctive relief against unlicensed persons attempting to practice medicine without a license. See Day v. Inland Empire Optical, Inc., 76 Wash. 2d 407, 456 P.2d 1011 (1969). Thus, this statute apparently broadens the standing to object to the unlicensed practice of medicine to include any person.


73. See Dowell, supra note 16.

74. See Wiorek, supra note 30, at 471–84 (reviewing the status of the corporate practice of medicine doctrine in each state in 1987).
repudiated the doctrine.\textsuperscript{75} Moreover, several states that recently applied the doctrine utilized it beyond its scope.\textsuperscript{76}

\textbf{A. The Illegality Defense Extends the Scope of the Doctrine}

Although the doctrine originally was established to shield patients from poor-quality care, increasingly it has been used as a sword to sever physician relationships. Corporate practice of medicine allegations are part of the growing illegality defense.\textsuperscript{77} The illegality defense is an extension of the general rule of law that courts will not enforce illegal contracts.\textsuperscript{78} Thus, parties may seek to escape their obligations under employment or other agreements for professional services with corporations by asserting an illegality defense based on the corporate practice of medicine prohibition.

A recent Illinois case\textsuperscript{79} illustrates how this defense can work. In 1992, Dr. Richard Berlin, Jr., signed a five-year exclusive employment agreement with Sarah Bush Lincoln Health Center. Berlin resigned in 1994 and began working for a neighboring clinic, in apparent violation of a non-competition clause.\textsuperscript{80} The hospital sued. Berlin responded that the contract violated the Illinois Medical Practice Act\textsuperscript{81} which prohibits the corporate practice of medicine. The trial court agreed, granted Berlin's motion for summary judgment, and held that the contract was not enforceable.\textsuperscript{82} The appellate court affirmed.\textsuperscript{83} \textit{Berlin} demonstrates how the corporate practice of medicine doctrine has moved beyond the scope of its original purpose.

\begin{footnotes}
\footnotetext[75]{Id. Cf. Terese Hudson, \textit{Hospitals Work Through the Corporate Practice Maze}, Hosp. \& Health Networks, Oct. 5, 1994, at 60, available in Westlaw, HHNTWK database, 1994 WL 2887124, at *3 (stating that 13 states actively enforce the corporate practice ban, 13 states allow physician employment by hospitals, and the rest are somewhere in the middle).}
\footnotetext[77]{See Michael W. Peregrine et al., \textit{Hospital/Physician Contracting and the Illegality Defense}, 27 J. Health \& Hosp. L. 129 (1994).}
\footnotetext[78]{"It is a general rule that where the contract grows immediately out of, and is connected with, an illegal act, a court of justice will not lend its aid to enforce it." Hederman v. George, 35 Wash. 2d 357, 361, 212 P.2d 841, 843 (1949).}
\footnotetext[79]{\textit{Berlin}, No. 95-MR-7 (5th Cir. Ill.).}
\footnotetext[80]{Id., slip op. at 6–7.}
\footnotetext[82]{\textit{Berlin}, No. 95-MR-7, slip op. at 9–10.}
\footnotetext[83]{\textit{Berlin}, 1996 WL 172738 at *1 (Ill. App. 4th Dist. Apr. 12, 1996) (No. 4-95-0569).}
\end{footnotes}
B. Recent Application of the Doctrine in Washington

The Washington Supreme Court most recently applied the corporate practice of medicine doctrine in 1988. In Morelli v. Ehsan, the court declared a limited partnership, where a physician and a nonphysician operated a medical clinic, to be illegal. Morelli is the only Washington case since 1950 to discuss the corporate practice prohibition.

In 1980, Tito Morelli and Dr. Mike Ehsan entered a limited partnership agreement to establish and operate a medical clinic. The clinic employed licensed physicians as the medical staff, who were paid on an hourly basis. The contract entitled Morelli and Ehsan to share equally in profits and losses, each receiving a salary for services rendered. The agreement granted each equal rights to manage the business and defined Morelli as "Director of Operations" and Ehsan as the "Medical Director." In 1985, Morelli petitioned the court for a dissolution of the partnership and an accounting. Ehsan moved to dismiss Morelli's complaint, arguing that the partnership agreement was illegal and void. Morelli claimed that he was not practicing medicine because his responsibilities were strictly limited to business aspects of the clinic while Ehsan's authority was limited to its medical affairs.

The court held the partnership illegal as a matter of law because it constituted the unlicensed practice of medicine. The court relied on section 18.71.011(1) of the Revised Code of Washington, which defines the practice of medicine. The court also interpreted the Professional Service Corporations Act to prohibit lay participation in a professional partnership as well as in a corporation.

Morelli illustrates that the corporate practice of medicine doctrine in Washington exceeds its original scope. Like the Berlin case, Morelli involves an illegality defense. Ehsan used the doctrine to defend against
Morelli’s accounting action. The state did not invoke the doctrine to protect patients from shoddy care, rather an individual successfully used the doctrine to avoid a legal obligation.

The precise operation of the doctrine is doubtful because no reported case or administrative decision in Washington discusses employment of a physician by a health care corporation. Standard Optical and Boren involved optometry and dentistry, respectively. Further, Morelli did not involve a health care corporation, but rather a business partnership. Thus, the existing case law leaves unanswered the current questions about the employment of physicians. However, a likely extrapolation from existing case law is that the doctrine prohibits the employment of physicians by any entity other than a professional corporation or HMO, even if the corporation only performs business functions.

### III. Washington’s Corporate Practice of Medicine Laws Are Inapposite to the Evolving Health Care Environment

Today’s health care industry differs from the one in which the corporate practice of medicine prohibition originated. The manner in which health care services are organized, delivered, and financed has significantly changed, but the corporate practice of medicine laws have not kept pace with these changes.

The health care environment of the early 1900s consisted of solo general practitioners. Physicians carried most of their equipment in black bags, and house calls were the norm. Hospitals were primarily religious and charitable in nature. Health insurance was not prevalent; hence, individuals made the bulk of all personal health care

95. Id. at 557, 756 P.2d at 130.
98. 110 Wash. 2d at 556, 756 P.2d at 129.
99. See supra part I.B.
100. See Chase-Lubitz, supra note 8, at 478–79.
101. See generally Starr, supra note 3, at 145–232 (discussing metamorphosis over time of hospital as institution).
expenditures. HMOs and other types of managed care organizations were nonexistent.

Gradually, physicians began to specialize, medical technology proliferated, hospitals provided increasingly complex care, and health insurance became common. In addition, health care costs rose dramatically. In response to escalating costs, private payers and employers increased efforts to "manage" the utilization of health care. Corporate entities, such as HMOs or PPOs, developed delivery systems to provide health services in a more cost-efficient manner. Thus, beginning in the late 1970s, the use of managed health care grew at a phenomenal rate. The ability to reduce total health care expenditures enhanced the spectacular growth in managed care enrollment.

A. A Conflict Between Modern Innovations and an Old Doctrine

Price sensitivity, growing competition, and spiraling costs characterize the modern health care environment. Recent predictions indicate that

103. Private health expenditures accounted for 86.4% of total health care expenditures in 1929. Id. at 242.
104. Id. at 251–58.
105. See generally Starr, supra note 3, at 145–232.
106. In 1935, Americans spent $2.9 billion on total health expenditures, which comprised 4% of the gross national product (GNP). See Kovner, supra note 102, at 242. Total health expenditures include health services and supplies, drugs and other medical nondurables, program administration, and research and construction. By 1960, total health expenditures exceeded $27 billion (5.3% GNP), and in 1993, Americans spent $884 billion (13.9% GNP) on total health expenditures, a 7.8% increase over 1992. See Katharine R. Levit et al., National Health Spending Trends, 1960–1993, Health Aff., Winter 1994, at 14–15. National spending for health care grew an average of 12.7% per year from 1970 to 1987. In addition, the rate of increase in health care costs consistently has far exceeded the rate of inflation in the general economy. See Kovner, supra note 102, at 240–69.
107. For example, HMO patients tend to utilize fewer hospital services and fewer costly and elective procedures. See Robert H. Miller & Harold S. Luft, Managed Care Plan Performance Since 1980: A Literature Analysis, 271 JAMA 1512 (1994).
108. Enrollment in HMOs grew rapidly during the 1980s, growing 300% in just eight years to include 29.3 million people by 1987. Further, of those receiving health insurance through the workplace, over 70% were enrolled in some type of managed-care plan. See Kovner, supra note 102, at 281. Managed care enrollment accounted for 58% of the private health insurance market in 1993. See Levit et al., supra note 106, at 23. See generally Rodney C. Armstead et al., Toward a 21st Century Quality-Measurement System for Managed-Care Organizations, Health Care Fin. Rev., Summer 1995, at 25–26. Managed-care contracts among Medicare beneficiaries have increased steadily. In 1987, about 1.7 million beneficiaries were enrolled in managed-care plans. By July 1995, over 3.5 million Medicare beneficiaries had enrolled in managed-care plans (an 18% increase over 1994). Id.
109. Data gathered from the Rand Health Insurance Experiment justify the conclusion that HMO care results in lower utilization and, thus, lower costs. See Edward H. Wagner & Turner Bledsoe, The Rand Health Insurance Experiment and HMOs, Med. Care, March 1990, at 191.
managed care will continue to grow dramatically. Another physician forecaster anticipates that the health care industry eventually will be composed primarily of corporate physicians working as employees of managed care plans, medical groups, and hospitals.

In Washington, recent state health reform measures endorsed managed care. The Legislature created the Washington Health Care Cost Control and Access Commission in 1990 to recommend changes to improve access to essential health services and stabilize the overall costs of health care in Washington. In 1992, the Commission recommended that a substantial majority of the state’s population should receive health care services through managed health care systems and integrated delivery systems. In response, the Legislature enacted the Health Services Act of 1993 to achieve these goals. Although the Legislature repealed sections of the act in 1995, the emphasis on managed care and integrated delivery remains clear. Moreover, market reforms indicate that Washington is experiencing increased managed care market penetration.

Health policy analysts, legislators, and presidential candidates have hailed managed care as an indispensable part of health care reform because of its proven ability to reduce costs. Some may dispute the propriety of shifting toward managed care, but it is the reality of our


17. See generally Kenneth I. Shine, Quality of Health and Health Care, 273 JAMA 244 (1995).
modern system. However, the corporate practice of medicine doctrine stands directly in the path of managed care growth. For example, fifty-nine percent of hospitals responding to a recent survey reported that physicians are requesting employment.\textsuperscript{118} New England had the highest employment rate (81 percent of hospitals responding to the survey actually employed physicians), while the Pacific region had the lowest (only 24 percent of hospitals responding to the survey actually employed physicians).\textsuperscript{119} The survey indicated that state laws that prohibited hospitals from hiring physicians were directly responsible for the differences among the regions.\textsuperscript{120}

B. Market Changes and Policy Concerns Diminish the Underlying Justifications for the Doctrine

Although an organization might be able to bypass the corporate prohibition (for example, by using the HMO exception),\textsuperscript{121} the validity of the doctrine must be re-evaluated in light of changes in the health care market and current policy concerns. Additionally, the doctrine merits review because current state and federal laws implicitly recognize corporate involvement in the practice of medicine through physician employment.

1. Professional Standards

Modern regulatory provisions protect professional standards more sensibly than the corporate practice prohibition. Licensing statutes, quality management mechanisms, and accreditation help to preserve medical professional standards and promote quality of care without hindering managed care development. These mechanisms supplant the need for the corporate practice of medicine doctrine.

\textit{State ex rel. Standard Optical Co. v. Superior Court} first articulated the concern that corporate involvement in medicine would destroy professional standards.\textsuperscript{122} However, \textit{Standard Optical} and the corporate practice prohibition evolved during a time when professional standards were not subject to the current standards of regulation. First,

\begin{itemize}
\item \textsuperscript{118} Deloitte & Touche, \textit{U.S. Hospitals and the Future of Health Care} 19 (5th ed. 1994).
\item \textsuperscript{119} \textit{Id.} at 20.
\item \textsuperscript{120} \textit{Id.}
\item \textsuperscript{121} \textit{See supra} notes 59–61 and accompanying text.
\item \textsuperscript{122} 17 Wash. 2d 323, 331, 135 P.2d 839, 843 (1943). \textit{See supra} notes 42–43 and accompanying text.
\end{itemize}
Washington’s licensing statutes currently require an inquiry into physician credentials. For example, hospitals have an affirmative duty to request information about any pending professional medical misconduct proceedings prior to hiring or granting clinical privileges. In addition, Washington’s HMO licensing law requires that an HMO conduct peer review, which includes examining physician credentials and monitoring physician competence in delivering health care services. Thus, the present licensing laws adequately protect against the corporate erosion of professional standards.

Second, quality management that is compulsory under several sources of legal authority helps to safeguard physician professional standards. Quality management includes functions such as peer review, utilization review, and credentials review. Washington law requires that hospitals, nursing homes, and managed care entities engage in quality management. Thus, quality management programs have diminished the need for the corporate practice of medicine doctrine to protect quality and professional standards.

Finally, the establishment of accrediting bodies, such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO)

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125. See Arthur F. Southwick & Debora A. Slee, Peer Review of Professional Practice, in The Law of Hospital and Health Care Administration 623 n.1 (2d ed. 1988) (asserting that although traditionally referred to as quality assurance (QA), because no committee can “assure” or guarantee quality of person or institutional health services, term quality management more accurately describes this function).
126. The sources of legal mandate include the Standards of the Joint Commission on Accreditation of Healthcare Organizations (which are admissible in evidence in a negligence or malpractice lawsuit); state statutory law regulating the licensure of hospitals, HMOs, and physicians; and federal statutory provisions creating bodies to review the quality and appropriateness of Medicare services. Id. at 623–25. In addition, the federal Health Maintenance Organization Act of 1973 required a QA program. See Conrad Sobczak et al., Quality Measurement and Management in an HMO Setting, 18 Top. Health Care Fin. 67 (1991).
128. Wash. Rev. Code § 70.41.200 (1994) (“Every hospital shall maintain a coordinated quality improvement program for the improvement of the quality of health care services rendered to patients and the identification and prevention of medical malpractice.”); Wash. Rev. Code § 18.51.007 (1994) (stating that nursing homes shall establish “an inspection and reporting system to insure that [they] are in compliance with . . . regulations pertaining to patient care”); Wash. Rev. Code § 48.46.030(1)(m) (1994) (requiring that HMOs provide a “description of the procedures and programs to be implemented to assure that the health care services delivered . . . will be of professional quality”).
129. The JCAHO currently accredits hospitals; however, in January 1994 JCAHO established a set of standards for accrediting networks in such areas as patients’ rights and responsibilities, continuum of care, information management, and performance improvement. See Karen Sandrick, Is
and the National Committee for Quality Assurance (NCQA)\textsuperscript{130} has weakened the doctrine's need law to protect professional standards. The JCAHO and NCQA scrutinize organizations to ensure that patients receive quality care.\textsuperscript{131} Accreditation protects quality and professional standards more effectively than the corporate practice prohibition because it provides for periodic review of an organization rather than a one-time inquiry into quality of care during a lawsuit. The accreditation mechanism protects professional standards even if an organization elects to decline accreditation. For example, if a hospital is not accredited, the JCAHO's standards nevertheless will help define the standard of care in a negligence action.\textsuperscript{132} In addition, pressure from employers, the largest provider of health insurance, has resulted in an increase in voluntary accreditation.\textsuperscript{133} These accrediting bodies are another device for promoting quality in health care that did not exist when the corporate practice prohibition developed and hence weaken the need for the doctrine.

2. Absence of Commercial Exploitation and Divided Loyalties

Washington case law also has articulated fears that corporate involvement in medicine would result in commercial exploitation and divide physician loyalties between the corporation and the patient.\textsuperscript{134} The courts were concerned that the physician would place the corporation's financial interests above patient welfare, resulting in lower quality of care.\textsuperscript{135} However, modern experience demonstrates that these fears have not materialized.


130. NCQA is the leading organization that accredits HMOs. NCQA had accredited 156 HMOs nationwide in 1994 and expects to have reviewed half of the nation's 600 or so HMOs by the end of 1995. \textit{Id}.

131. \textit{Id}.


133. A 1994 survey conducted by the Managed Health Care Association, an employer trade group that promotes managed care, found that 24% of the member companies required accreditation, and 63% of the remaining companies planned to require accreditation in the next one to three years. \textit{See} Sandrick, \textit{supra} note 129.


135. \textit{See} Boren, 36 Wash 2d. at 531, 219 P.2d at 571; \textit{Standard Optical}, 17 Wash. 2d. at 332, 135 P.2d at 843.
Corporate involvement in the health care market has increased despite corporate practice bans. Corporate entities such as HMOs and PPOs have experienced dramatic growth. Yet, evidence of reduced quality of care resulting from alleged commercial exploitation and divided physician loyalties has not emerged. In fact, a recent study examining the quality of care in a managed care setting found no reduction in quality.

Furthermore, as previously noted, extensive regulations ensure that patients receive adequate care. Processes such as quality assurance and utilization review examine physician practice procedures and patient relationships, and intrude on those relationships if necessary. In addition, no evidence supports the assertion that physicians previously devoted to patient care will suddenly lose their focus on patient advocacy once a corporation enters the relationship. All physicians are bound by the Hippocratic oath and professional ethics standards, regardless of corporate affiliation. Moreover, the established law in all states holds all physicians to the same standard in malpractice cases.

Finally, the divided loyalty argument did not prevent the Washington Legislature from enacting the Professional Service Corporations Act. In terms of profit-making objectives, there is little difference between a doctor employed by a group of physicians and a doctor employed by a corporation controlled by non-physicians. Each entity has the same potential to divide physician loyalty between the corporation and patient.

136. See supra notes 106-08 and accompanying text.
137. See Sheldon Greenfield et al., Outcomes of Patients with Hypertension and Non-Insulin-Dependent Diabetes Mellitus Treated by Different Systems and Specialties: Results From the Medical Outcomes Study, 274 JAMA 1436 (1995).
138. See supra text accompanying notes 125-31.
139. For example, Wash. Rev. Code section 70.41.200 provides that a physician may lose certain clinical privileges, such as operating privileges, if he or she refuses to alter unsound practice procedures. See Wash. Rev. Code § 70.41.200(1)(b) (1994).
140. All physicians taking the oath swear that “the regime I adopt shall be for the benefit of my patients according to my ability and judgment and not for their hurt or for any wrong.” The oath does not distinguish corporate physicians from other physicians. See Kovner, supra note 102, at 477.
141. The Washington Legislature has codified the proof necessary to show that an injury was caused by failure to follow the accepted standard of care. The statute applies to all physicians and states that a “health care provider [who] failed to exercise that degree of care . . . expected of a reasonably prudent health care provider” may be found negligent. Wash. Rev. Code § 7.70.040 (1994) (emphasis added).
142. See supra notes 56–58 and accompanying text.
3. Misplaced Concern with Lay Control of Physicians

Washington courts in the first half of this century also voiced concern about lay control of physicians. The corporate practice of medicine doctrine evolved to protect physician autonomy and to ensure that only those with the necessary knowledge and training were exercising medical judgment regarding diagnosis and treatment of disease. There is a crucial difference, however, between corporate involvement in the business aspects of health care and the corporate practice of medicine.

In several states, courts distinguish between the management functions of the corporation and the actual furnishing of medical services by professionals. For example, in Daw's Critical Care Registry, Inc. v. Department of Labor, a Connecticut court differentiated between providing nurses and caring for patients. The defendant corporation in Daw's had brokered nursing services to medical facilities. The court held that the "business of providing health care personnel: does not translate into the business of caring for patients." The court specifically noted that the corporation had no control over how the nurses provided their services. Similarly, in Women's Medical Center v. Finley, a New Jersey appellate court distinguished nonprofessional business matters, such as paying office expenses and maintaining business records, from professional medical practices. The court recognized that all health care providers or entities must perform business, administrative, and management chores. As long as the manner of their performance "does not impinge upon professional control by the physicians of the medical practice," the court found that the business management of the practice does not affect the delivery of health care services.

In each of the Washington cases, however, the court rejected the distinction between the professional aspects of medicine and its business

144. See supra text accompanying notes 12–15.
146. Id. at 636.
147. Id.
148. Id.
150. Id. at 73.
151. Id.
functions. The unwillingness of the Washington Supreme Court to recognize this distinction has led to the unnecessary and confused expansion of the doctrine. The development of the corporate practice prohibition from the licensing statutes indicates that the critical function of the doctrine is to ensure physician autonomy in medical decisions. Physician contracting and employment relationships are not medical decisions and accordingly should not be governed by the doctrine.

The Washington Legislature has implicitly distinguished the actual practice of medicine from business activities. By definition, practicing medicine includes such activities as diagnosing, advising, prescribing, curing, or administering drugs. This definition does not encompass business activities. Furthermore, the Legislature defines health care services as “medical, surgical... hospital and other therapeutic services,” but not as business or management functions. Because Washington’s corporate practice of medicine doctrine fails to recognize this very crucial distinction, the concern over lay control of physicians by corporate actors is largely misplaced.

C. Legislative Acceptance of and Acquiescence in Corporate Involvement in Health Care

In addition to the historical changes that have weakened the doctrine’s underlying justifications, the doctrine does not reflect the current state and federal legislative recognition of corporate participation in medicine. The Washington Legislature has implicitly accepted and acquiesced in corporate involvement in health care. Further, both state and federal law explicitly sanction physician employment.

1. Professional Service Corporations Act

In 1983, the Legislature amended the Professional Service Corporations Act to permit HMOs to employ physicians to practice


153. See supra notes 12–15 and accompanying text.

154. See Wiorek, supra note 30, at 467.


By creating the HMO exception, the Legislature disregarded the concerns underlying the corporate practice of medicine doctrine.

The HMO structure incorporates many of the characteristics that the corporate practice of medicine doctrine was designed to protect against. For example, HMOs use a fixed-budget structure, which creates management incentives to pressure physicians not to order expensive tests of marginal diagnostic value. Furthermore, an HMO's use of utilization review programs has the potential to impose corporate control over treatment decisions. Finally, the HMO structure creates an inherent risk of physician loyalty to the corporation at the expense of the patient.

2. The Plain Language of Statutory Provisions Refutes the Validity of the Corporate Practice of Medicine Doctrine

Several statutory provisions undermine the corporate practice of medicine doctrine. First, the Medical Malpractice Prevention Act of 1986 explicitly contemplates hospital employment of physicians. The act provides that before “hiring a physician, a hospital or facility ... shall request from the physician” certain detailed information relevant to the credentialing of the individual. Second, section 4.24.240 of the Revised Code of Washington grants immunity from civil damage actions arising out of peer review activities. The statute specifically covers entities that employ physicians or surgeons. A plain reading of both statutes demonstrates the legislative recognition of physician-hospital employment relationships.

In addition, the language of both sections 18.71.011 and 18.71.021 of the Revised Code of Washington casts doubt on the validity of the corporate practice of medicine doctrine. Under section 18.71.011, “a person is practicing medicine” if he engages in any of the activities listed in the statute. The statute does not refer to a corporate entity practicing medicine. Likewise, Washington law requires that a person obtain a

157. See supra note 61 and accompanying text.
158. See Kovner, supra note 102, at 255–56.
159. See Dowell, supra note 16.
license before practicing medicine, and does not mention a corporate entity. It is difficult, therefore, to understand how a corporation can be engaged in the practice of medicine, when by statutory definition, only individuals practice medicine. The Nebraska Supreme Court, which never adopted the corporate practice of medicine doctrine, gave this same explanation in State Electro-Medical Institute v. State. The court held that the medical licensure statutes did not apply to corporations; it ruled that a corporation is incapable of practicing medicine because an impersonal entity cannot diagnose or treat a disease.

Finally, the plain language of several provisions of federal law explicitly recognizes physician employment by health care entities. Both the federal fraud and abuse provisions and the Stark I Amendment specifically recognize physician employment. Congress, by enacting these provisions, did not share the corporate practice of medicine concerns of the Washington courts.

The fraud and abuse provisions, also known as the anti-kickback statutes, prohibit the receipt or payment of remuneration in exchange for referring a patient for services paid for by the Medicare program. Whoever knowingly and willfully induces such referrals is subject to criminal prosecution and a substantial fine. Rules issued by the Officer of Inspector General create “safe harbors” that immunize various payment practices and business arrangements from prosecution under the anti-kickback provisions. An employment relationship is a “safe harbor” under the fraud and abuse statute.

The Stark I Amendment bans certain physician self-referral in the Medicare program. The enactment prohibits a physician from referring Medicare patients to an entity for particular designated health services if

165. See supra note 15; see also State ex rel. Standard Optical Co. v. Superior Court, 17 Wash. 2d 323, 328, 135 P.2d 839, 841 (1943) (stating that although “a corporation is in some sense a person . . . yet, as regards the learned professions which can only be practiced by persons who have received a license . . . it is recognized that a corporation cannot be licensed to practice such a profession”) (quoting 13 Am. Jur. Corporations § 837).
166. 103 N.W. 1078 (Neb. 1905).
167. Id. at 1079.
170. A person violating the statute is guilty of a felony and upon conviction shall be fined not more than $25,000, or imprisoned for not more than five years, or both. 42 U.S.C. § 1320a-7b.
the physician has a financial relationship with that entity.\textsuperscript{173} However, federal law provides a specific exception to this general prohibition when the physician has a bona fide employment relationship with a hospital.\textsuperscript{174} So long as the physician is employed for identifiable services and the amount paid to the physician is consistent with the fair market value of the services, the payments do not run afoul of the Stark I Amendment. The statute further provides that hospitals may pay employed physicians a productivity bonus without violating the law.\textsuperscript{175} The fraud and abuse provisions and the Stark I Amendment apply to all Washington providers receiving federal Medicare funds.\textsuperscript{176} Federal Medicare laws are critical to Washington health care consumers and providers. Receipt of Medicare funds is necessary to ensure patient access to health care. Further, Medicare reimbursement comprises a large portion of provider revenue.\textsuperscript{177} Thus, public policy concerns demand that Washington law avoid conflict with federal Medicare law.

\subsection*{D. The Illegality Defense}

Finally, Washington's corporate practice of medicine doctrine should be reconsidered because it is currently employed far beyond its original intended scope. The doctrine was established to protect patients and safeguard physician autonomy over medical decisions.\textsuperscript{178} In \textit{Standard Optical}\textsuperscript{179} and \textit{Boren},\textsuperscript{180} the state brought actions against corporations to protect the public. The court applied the doctrine in these early cases to achieve the doctrine's fundamental goals. More recently, however, protecting patients and safeguarding physician autonomy was not the central issue of a judicial decision involving the doctrine. In \textit{Morelli}, a party used the doctrine to defend against an otherwise legal obligation.\textsuperscript{181} The illegality defense does not effectuate the intended aims of the

\begin{thebibliography}{99}
\bibitem{173} 42 U.S.C. § 1395nm(a) (1994).
\bibitem{174} 42 U.S.C. § 1395nn(e)(2).
\bibitem{175} 42 U.S.C. § 1395nn(e)(2).
\bibitem{176} 42 U.S.C. § 1320a-7b; 42 U.S.C. § 1395nn(a).
\bibitem{177} Medicare is the single largest purchaser of physicians' services in the United States. Payments from the Medicare program account for over 25\% of physicians' gross revenues. \textit{See} Physician Payment Review Commission, \textit{supra} note 4, at 77.
\bibitem{178} \textit{See supra} text accompanying notes 14--20.
\bibitem{179} State ex rel. Standard Optical Co. v. Superior Court, 17 Wash. 2d 323, 135 P.2d 839 (1943).
\bibitem{181} Morelli v. Ehsan, 110 Wash. 2d 555, 756 P.2d 129 (1988).
\end{thebibliography}
doctrine, but rather, operates to interfere with contractual relationships. Therefore, the doctrine should be narrowed to avoid further use of this practice and instead should focus on the goals underlying the doctrine's development.

IV. NARROWING THE SCOPE OF THE CORPORATE PRACTICE OF MEDICINE DOCTRINE

Although the corporate practice of medicine doctrine is outdated, the doctrine should not be abolished. Its remaining justification is the prohibition of lay control over physician autonomy in medical decisions. The doctrine should serve a single critical function in the modern health care environment—that of protector of physician sovereignty in health care decisions. Narrowed in this manner, the doctrine can benefit both physicians and patients without infringing on modern developments that have made corporate involvement in the delivery of health care services a vital necessity.

A recent South Dakota statute provides a useful model by which the Washington Legislature might amend chapter 18.71 of the Revised Code of Washington to appropriately narrow the corporate practice of medicine doctrine. Adopted in 1993, the South Dakota statute provides, in part:

It is the public policy of this state that a corporation may not practice medicine or osteopathy. A corporation is not engaged in the practice of medicine or osteopathy and is not in violation of [this section] by entering into an employment agreement with a physician licensed pursuant to this chapter if the agreement or the relationship it creates does not . . . [i]n any manner, directly or indirectly, supplant, diminish or regulate the physician's independent judgment concerning the practice of medicine or the diagnosis and treatment of any patient.182

An amendment based on the South Dakota provision would repair several weaknesses in Washington law. First, the statute removes any doubt concerning the extent of the corporate prohibition. It makes clear that the practice of medicine by any corporation is prohibited whether the entity is a hospital, nursing home, managed care entity, or any other health delivery organization. Thus, South Dakota health care providers and their attorneys know which organizations are included in the

prohibition. Washington providers, in contrast, have little guidance as to the extent of the Washington prohibition. Washington case law has spoken only to dentistry, optometry, and a medical partnership. The case law never has addressed physician employment. Clarifying the extent of the corporate prohibition promotes certainty, and would facilitate planning, by helping Washington providers determine which arrangements are lawful.

Second, the South Dakota statute clearly authorizes the employment of licensed physicians while protecting physician autonomy in medical decisions. By allowing physician employment, the law recognizes the critical distinction between business activities and the actual practice of medicine. Moreover, it effectuates the last remaining justification for the corporate practice of medicine doctrine: preventing lay control of physicians’ medical decisions. Conversely, the Washington doctrine fails to distinguish between business and medical activities. No Washington statute specifically prohibits lay control of physician judgment.

Finally, the South Dakota statute curtails the use of the illegality defense. The corporate practice of medicine doctrine never was intended to interfere in contractual relationships or to be utilized to harass competitors. Unfortunately, the doctrine is currently employed in this manner. The South Dakota statute limits corporate practice of medicine as an illegality defense by clearly defining what constitutes a violation and by excluding physician employment from the definition. Thus, providers are certain about which relationships are lawful and need not worry that an unclear law will be used later to interfere in a contractual relationship.

Accordingly, the Washington Legislature should adopt an amendment to chapter 18.71 of the Revised Code of Washington that is similar to section 34-4-8.1 of the South Dakota statute. Such legislation would narrow the scope of the doctrine while retaining sufficient safeguards to protect physician autonomy and prevent deterioration of patient care.

183. All corporations, regardless of the specific type of the organization, are prohibited from practicing medicine. S.D. Codified Laws Ann. § 36-4-8.1 (stating that “a corporation may not practice medicine”).

184. See S.D. Codified Laws Ann. § 36-4-8 (stating that the unlicensed practice of medicine is misdemeanor); S.D. Codified Laws Ann. § 36-4-8.1 (prohibiting a corporation from practicing medicine) S.D. Codified Laws Ann. § 36-4-9 (defining the practice of medicine).
IV. CONCLUSION

The corporate practice of medicine doctrine as it now operates in Washington is antiquated and should be reconsidered. The doctrine arose in an era much different from the health care environment of today. Although the justifications for the doctrine were once valid, they are presently addressed by other measures and hence, have lost their legitimacy in the new health care market. Modern regulations are available to protect the patient from the "quackery" that the corporate prohibition once sought to avoid. In addition, use of the doctrine in an illegality defense illustrates that the doctrine's current use exceeds its original purpose.

Although the Washington Legislature has implicitly accepted corporate involvement in medicine, it should enact legislation to explicitly clarify and narrow the reach of the corporate practice of medicine doctrine. This would clarify the extent of the prohibition, explicitly authorize physician employment, and curtail the use of the illegality defense. Amending Washington law in accordance with the South Dakota statute would remove any lingering doubts regarding the scope and applicability of the corporate practice of medicine doctrine in Washington.