Dr. Tele-Corporation: Bridging the Access-to-Care Gap

Nader Amer

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Comments

Dr. Tele-Corporation: Bridging the Access-to-Care Gap

Nader Amer*

ABSTRACT

The United States is currently confronting an access-to-healthcare crisis, which rural regions are experiencing at a disproportionate rate. Many commentators have touted telemedicine as a solution for the access-to-care issue. Telemedicine uses video and telecommunication technology to allow physicians to treat patients from distant locations and thus facilitates a more equal distribution of physicians throughout the United States.

Although the telemedicine industry is quickly growing, the corporate practice of medicine doctrine impedes the industry's expansion and consequently obstructs a viable solution to the access-to-care crisis. Generally, the corporate practice of medicine doctrine prohibits corporations and limited liability companies

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from employing physicians. The doctrine stems from a concern that the corporate business model’s inherent focus on the “bottom line” will inevitably require the sacrifice of quality care for efficiency.

States should abandon the corporate practice of medicine doctrine because the concerns that the doctrine seeks to address are ill-founded and do not account for the modern state of the healthcare industry. Further, corporate telemedical providers that furnish substandard care would be prime targets for class-action lawsuits or widespread litigation due to telemedicine’s expansive reach and the corporate form’s ability to facilitate business growth. Lawsuits, including class actions, will effectively deter any degradation in quality of care because corporations who render substandard care would face immense liability-risk exposure and a critical ultimatum: reform or fail.

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I. INTRODUCTION

The American healthcare system is overburdened, inefficient, and underserved.1 Although innovations in modern medicine have begun to address healthcare quality and access concerns, state and federal laws have failed to keep pace, standing as obstacles to the advancement and expansion of the healthcare industry.2 One particular healthcare innovation suffering from inefficient regulation is telemedicine.3

Broadly speaking, telemedicine refers to “the use of advanced telecommunications technologies to exchange health information and provide healthcare services across geographic, time, social and cultural barriers.”4 Telemedicine provides numerous advantages to

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1. See Carl F. Ameringer, State-Based Licensure of Telemedicine: The Need for Uniformity but Not a National Scheme, 14 J. HEALTH CARE L. & POL’Y 55, 56 (2011) (characterizing the healthcare system as overburdened); Shortage Areas, HRSA DATA WAREHOUSE, https://bit.ly/2jwIJBl (last visited Oct. 11, 2017) (indicating 3,587 medically underserved areas in the United States and 422 medically underserved U.S. populations) (follow “Primary Care HPSAs” PDF link under the “Quick Reports” section) (this source updates on a daily basis; the October 11, 2017 version is on file with author); see also Stephanie Gunselman, Note, The Conrad “State-30” Program: A Temporary Relief to the U.S. Shortage of Physicians or a Contributor to the Brain Drain?, 5 J. HEALTH & BIOMED. L. 91, 94 (2009) (discussing the shortage of healthcare physicians in United States).


3. Sahdev, supra note 2, at 1816; Ewell, supra note 2, at 69–70.

4. Jim Reid, A Telemedicine Primer: Understanding the Issues 10 (1996). Jurisdictions and medical authorities vary widely in the definition they ascribe to the term telemedicine; authorities sometimes use telemedicine interchangeably with telehealth, E-health, E-medicine, and cybermedicine. See, e.g., Jessica W. Berg, Ethics and E-Medicine, 46 ST. LOUIS L.J. 61, 61 (2002); see also Ewell, supra note 2, at 69–70. For this Comment’s definition of telemedicine see infra notes 36–37 and accompanying text.
patients.\textsuperscript{5} For example, Patti Cox, a 55-year-old woman living in Milford, New Hampshire, suffered from an anterior communicating artery aneurysm.\textsuperscript{6} Cox’s primary care physician was unable to schedule a surgical consult with Cox until nearly a month after her initial diagnosis, and he could not schedule Cox for surgery until more than half a month after the scheduled consult.\textsuperscript{7} Cox was distressed and anxious to see a doctor because several members of her family died from similar neurological conditions.\textsuperscript{8} The next closest clinic, however, was six hours away.\textsuperscript{9}

Fortunately, Cox’s primary physician referred her to the Dartmouth-Hitchcock Center for Telehealth, where Cox was able to schedule a virtual consult within days.\textsuperscript{10} During Cox’s virtual consult, Dr. Singer appeared on screen and reviewed Cox’s CT scans with her.\textsuperscript{11} Dr. Singer then discussed the surgical procedure in detail with Cox and quelled Cox’s concerns.\textsuperscript{12} “Five days later, [Dr.] Singer performed a coil embolization on Cox’s brain aneurysm,” providing her the lifesaving treatment that would have otherwise been unavailable to her for over three weeks.\textsuperscript{13}

Stories like Cox’s are commonplace;\textsuperscript{14} yet, so too are the legal impediments to telemedicine’s proliferation.\textsuperscript{15} One significant bar-
rrier to the proliferation of telemedicine is the corporate practice of medicine doctrine. Generally, the corporate practice of medicine doctrine prevents corporations, limited liability companies, and non-physicians from employing physicians or having any ownership interest in physician practices. The purpose of the doctrine is to prevent the commercialization of the medical profession and to protect professional judgments, thereby ensuring patient quality of care.

bit.ly/2AvhpcU [https://perma.cc/Z2KA-M9P4]. Dr. Rockwell describes the current legal and regulatory landscape that providers of telemedicine must confront, specifically identifying the following: (1) FDA regulations of telemedical device technology; (2) federal data and privacy laws like HIPPA; (3) scope-limiting restrictions on the provision of telemedicine; (4) Medicare and Medicaid reimbursement restrictions; (5) interstate licensure restrictions; and (6) medical malpractice coverage.

16. See *In re Am. Med. Ass’n*, 94 F.T.C. 701, 701 (1979), 1979 WL 199033 (ordering American Medical Association to “cease engaging in any action that would . . . characterize as unethical the participation by non-physicians in the ownership or management of health care organizations” upon finding that the restrictions had the purpose and effect of restraining competition); see also Adam M. Freiman, Comment, *The Abandonment of the Antiquated Corporate Practice of Medicine Doctrine: Injecting a Dose of Efficiency into the Modern Health Care Environment*, 47 EMORY L.J. 697, 698 (1998) (discussing how the corporate practice of medicine doctrine stands as a barrier to progression and efficiency in the healthcare industry). Other obstacles, such as state licensing laws, also pose barriers to telemedicine’s expansion. See Rockwell, *supra* note 15, at 41. States, however, have begun to create interstate licensing compacts, and thus, licensure laws may not pose as large of an obstacle for telemedicine to overcome in the near future. See, e.g., COLO. REV. STAT. § 24-60-3602 (2018); WYO. STAT. ANN. § 33-26-702 (2018); see also INTERSTATE MED. LICENSURE COMPACT, HTTPS://BIT.LY/2RCV8JU [HTTPS://PERMA.CC/2RJX-EN4M]. Licensure laws, however, are beyond the scope of this Comment.


In recent years, however, the doctrine has gone unenforced.\textsuperscript{19} Due to the current state of the healthcare marketplace, the public policy grounds that initially gave rise to the doctrine are largely irrelevant,\textsuperscript{20} especially in the context of telemedicine.

This Comment analyzes the corporate practice of medicine doctrine in the context of telemedicine and how the doctrine’s existence functions as an impediment to providing expansive access to healthcare. This Comment also considers the consequences of abandoning the doctrine in the telemedical context, giving particular focus to patient safety and quality of care. Part II.A discusses the current uses of telemedicine,\textsuperscript{21} the advantages the industry provides,\textsuperscript{22} and the effects telemedicine has had on the healthcare market.\textsuperscript{23} Part II.A also provides a brief overview of the various entity forms available to telemedical providers and discusses why the corporate form\textsuperscript{24} is often seen as the most advantageous entity form.\textsuperscript{25} Part II.B discusses the origin of the corporate practice of medicine doctrine,\textsuperscript{26} the theories behind the doctrine’s implementation,\textsuperscript{27} the doctrine’s current status in the modern healthcare climate,\textsuperscript{28} and the manner in which the doctrine impedes the proliferation and growth of telemedicine.\textsuperscript{29} Part III argues for abandoning the corporate practice of medicine doctrine and details how the advantages of telemedicine outweigh the inherent concerns of abandonment.\textsuperscript{30} Part III further argues that any possible degradation in patient quality of care that may result from abandoning the doctrine would be short lived and deterred as a result of widespread litigation, including class-action lawsuits.\textsuperscript{31} Due to telemedicine’s expansive

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\textsuperscript{19} FURROW ET AL., supra note 17, at 196–97.
\textsuperscript{20} Id.
\textsuperscript{21} See infra notes 35–48 and accompanying text.
\textsuperscript{22} See infra notes 49–82 and accompanying text.
\textsuperscript{23} See infra notes 83–118 and accompanying text.
\textsuperscript{24} Although this Comment uses the phrase “corporate form” to facilitate the discussion, the reader should understand the phrase to also encompass limited liability companies unless context requires otherwise.
\textsuperscript{25} See infra notes 83–118 and accompanying text.
\textsuperscript{26} See infra notes 119–39 and accompanying text.
\textsuperscript{27} See infra notes 140–41 and accompanying text.
\textsuperscript{28} See infra notes 142–54 and accompanying text.
\textsuperscript{29} See infra notes 142–54 and accompanying text.
\textsuperscript{30} See infra notes 155–222 and accompanying text.
\textsuperscript{31} See infra notes 210–22 and accompanying text.
reach, corporate providers who furnish substandard care serve as prime candidates for class-action lawsuits or, at minimum, targets for widespread litigation. The immense liability exposure that accompanies such lawsuits would function as a sufficient check on any corporate desire to sacrifice quality of care. Accordingly, substandard care providers would face the prospect of either reforming or failing.

II. BACKGROUND

A. Telemedicine: Industry Overview

Before discussing the implications of the corporate practice of medicine doctrine on the telemedical industry, it is necessary to understand the current telemedical marketplace, the structure of the marketplace’s providers, and telemedicine’s impact on the overall healthcare system.

1. What Is Telemedicine and What Services Does the Industry Offer?

A multitude of jurisdictions and medical authorities provide varying definitions for telemedicine. For purposes of this Comment, Texas law provides an operative definition for telemedicine. Telemedicine is:

[A] health care service delivered by a physician licensed in this state, or a health professional acting under the delegation and supervision of a physician licensed in this state, and acting within the scope of the physician’s or health professional's license to a

32. See infra notes 210–22 and accompanying text.
33. See infra notes 210–22 and accompanying text.
34. See infra notes 210–22 and accompanying text.
35. See Ameringer, supra note 1, at 62–63 (noting varying definitions amongst jurisdictions and medical boards). Ameringer goes on to indicate that each definition of telemedicine includes the following: “(1) ‘the geographic separation between two or more participants and/or entities engaged in health care,’ (2) ‘the use of telecommunication and related technology to gather, store and disseminate health-related information,’ and (3) ‘the use of electronic interactive technologies to assess, diagnose and/or treat medical conditions.’” Id. (quoting SPECIAL COMM. ON TELEMEDICINE, N.Y. BD. OF PROF’L MED. CONDUCT, STATEMENTS ON TELEMEDICINE BOARD FOR PROFESSIONAL MEDICAL CONDUCT (2009)).
36. This Comment adopts Texas’s definition for telemedicine because Texas has one of the highest shortages of healthcare professionals in the United States. See Gilbert Eric Deleon, Comment, Telemedicine in Texas: Solving the Problems of Licensure, Privacy, and Reimbursement, 34 ST. MARY’S L.J. 651, 659–63 (2003) (discussing Texas’s healthcare professional shortage in comparison to other areas of the country). In an effort to address these issues, Texas has often been at the forefront of legislation geared toward expansion of access to healthcare and telemedicine. See id. at 652–53.
patient at a different physical location than the physician or health professional using telecommunications or information technology.37

Today, the telemedical industry encompasses a variety of services. For instance, patients can schedule and attend virtual visits with physicians through companies like American Well.38 Patients need only create an account and provide their background information to see a physician.39 Thereafter, the American Well website presents patients with a list of available doctors to choose from, along with the doctors’ experience levels and customer ratings.40 Patients then may begin their virtual visit, wherein the physician can review a given patient’s history, answer questions, provide a diagnosis, treat the patient, and prescribe medications.41 This form of telemedicine service can also include remote patient monitoring, wherein patients use devices that “remotely collect and send data to a home health agency or a remote diagnostic testing facility (RDTF) for interpretation,” thus supplanting the use of in-home nursing.42

Another form of telemedicine takes place in the clinical context.43 In the clinical setting, a specialist at a distant location provides supporting services to an on-site provider, who essentially functions as the specialist’s hand in rendering diagnoses or treatments.44 The specialist can utilize high-definition video and audio to examine and communicate with the patient.45 Further, the specialist can read the patient’s diagnostic information in real time, and in some instances, may prescribe medication remotely.46 In its most advanced form, telemedicine can take the form of telesurgery or

37. TEX. OCC. CODE ANN. § 111.001(4) (West 2017).
39. Id.
40. Id.
41. Id.
43. See Ewell, supra note 2, at 69.
44. See id.
46. See A Robot Helped Save Him, supra note 45; see also Telemedicine at Your Bedside, supra note 45.
cybersurgery. In telesurgery, a physician located at a different site than the patient utilizes a robot to conduct surgery remotely.

2. The Impact of Telemedicine on Access to Healthcare

Although “[t]he United States spends more money than any other country in the world on health services, . . . Americans still struggle to access affordable care.” Telemedicine may present a viable solution to America’s access-to-care issue. To understand why, it is necessary to examine the underlying sources of the access-to-care problem.

One of the main obstacles to healthcare access is the shortage of health professionals in the United States. As of 2019, the U.S. Department of Health and Human Services indicated that only 43.85 percent of the need for primary medical care professionals is being met. Commentators attribute this overall shortage to the low number of graduates planning to work in primary care, the

48. E.g. Ewell, supra note 2, at 69–70; see Goldberg, supra note 47, at 225–26.
49. Sahdev, supra note 2, at 1821.
50. Id. at 1815.
51. See id. (identifying the primary-care physician shortage and the cost associated with in-person physician visits as barriers to access of healthcare).
52. Designated Health Professional Shortage Areas Statistics, HRSA Data Warehouse [hereinafter HHRS Shortage Area Statistics], https://bit.ly/2Tvgssh [https://perma.cc/Q2FY-49AJ] (follow “Designated HPSA Quarterly Summary” PDF link under the “Download Data” subheading, which can be found underneath the “Related Content” section heading). This source updates on a daily basis; however, the original document is on file with author.
53. See Kathleen Barnes et al., Osteopathic Schools Are Producing More Graduates But Fewer Are Practicing in Primary Care (2015) https://bit.ly/2Fe40cP [https://perma.cc/G4BU-9AXJ] (discussing factors leading to shortage of graduates becoming primary care physicians); Gunselman, supra note 1, at 94 (noting factors that exacerbate the health professional shortage as including fewer graduates planning to work as primary care physicians and general surgeons, which is due in part to the high cost of medical school prompting graduates to specialize in more lucrative practices). Gunselman notes that primary care physicians and general surgeons function as the “gatekeepers” of patient care, which is why the low number of such professionals exacerbates the rate at which patients are in need of care. Id.
aging Baby Boomer population, and the expansion of coverage under the Affordable Care Act.

Further, this shortage of health professionals exists at a disproportionate rate in rural regions, which is especially true in the case of specialists. The low pay physicians receive in rural areas, the low quality of life associated with practicing in rural areas, and the limited access to training in nonurban areas are significant causes of the rural healthcare professional shortage. Some commentators also correlate the rural health professional shortage with the fact that teaching hospitals are mainly located in metropolitan areas.

The access-to-healthcare problem in both the rural and the urban context is also attributable to “costs associated with seeing a physician in-person, including taking time off from work and ar-

54. Paul Barr, Baby Boomers Will Transform Health Care as They Age, HOSP. & HEALTH NETWORKS (Jan. 14, 2014), https://bit.ly/2ihDtxE [https://perma.cc/9W33-M9ZP]; see Gunkelman, supra note 1, at 94. The aging Baby Boomer population is relevant for two reasons. First, medical schools kept enrollment stagnant for two decades because advisory groups failed to take into account the aging Baby Boomer population. Id. The Baby Boomer population consists of approximately 250,000 physicians, many of whom will retire by 2020. Id. Second, and more important for purposes of this Comment, the aging population will require more round-the-clock care, thus increasing the number of patients and, consequently, the number of medical professionals needed to provide that care. See Aging Baby Boomers Present Array of Healthcare Challenges, PHYSICIANS NEWS NETWORK (Apr. 17, 2017), https://bit.ly/2AxgkkP [https://perma.cc/8XQS-4DJU]; see also Sahdev, supra note 2, at 1823 (discussing how the aging American population will eventually need more services, thereby further burdening an already overwhelmed system).

55. See Sahdev, supra note 2, at 1823 (“The [physician] shortage is exacerbated by the expansion of coverage under the [Affordable Care Act] . . . .”).

56. Gunkelman, supra note 1, at 95; see HHRS Shortage Area Statistics, supra note 52, at 3 (identifying rural regions as accounting for approximately 60 percent of total health professional shortage designations). Notably, such regions also suffer from preventable ailments at a disproportionate rate. See U.S. DEPT OF HEALTH & HUMAN SERVS., REPORT TO CONGRESS: E-HEALTH AND REMEDEY 4 (2016) [hereinafter REPORT TO CONGRESS], https://bit.ly/2SI5boF [https://perma.cc/M9CY-73RP].

57. Sahdev, supra note 2, at 1822.


59. See id. (“[R]ural physicians suffer from professional isolation[,]” and because of the shortage in professionals, “rural physicians are often on call for twenty-four hour emergency care . . . . and unable to receive adequate time off.”).

60. See Daniel McCarthy, Note, The Virtual Health Economy: Telemedicine and the Supply of Primary Care Physicians in Rural America, 21 AM. J.L. & MED. 111, 120 (1995) (discussing the lack of continuing education opportunities for physicians in rural areas, overrepresentation of students with metropolitan backgrounds in medical schools, and correlation between a physician’s geographical background and the physician’s geographic area of practice).

61. Id.
ranging travel.” The healthcare professional shortage exacerbates healthcare costs by creating longer wait times for patients, which often “results in [patients undergoing] unnecessary and expensive visits to urgent care and emergency departments for minor concerns.” Individuals who opt out of receiving care for minor injuries or illnesses due to the difficulties that accompany obtaining care further compound the access-to-care problem. The individual’s inability to obtain care may result in aggravated conditions that require more extensive treatment and often a more expensive bill.

Although Congress has attempted to address the access-to-care issue through various means, telemedicine may present the most effective solution. Telemedicine provides an avenue for physicians to circumvent geographic barriers and meet the needs of underserved communities. Further, telemedicine’s ability to circumvent geographic bar-
riers would also circumvent physician quality-of-life concerns in several respects. First, telemedical providers would alleviate the workload of rural physicians by either taking on more of the rural physicians' patients through a collaborative telemedical network system or furnishing preventative-care services to at-home patients. This strategy would thwart the number of emergent situations requiring the attention of an on-site physician. Second, telemedicine would provide rural physicians with more opportunities for continuing medical education and would “reduce[] professional isolation by allowing physician-to-physician consultation.” Third, physicians in metropolitan areas would not have to relocate and accclimate to rural life, thus furnishing rural providers with access to specialists that otherwise would be unavailable.

Telemedicine would also address the problems associated with the patient-population increase in several ways. As discussed above, the convenience of telemedicine will prompt more Americans to seek preventative care, thereby decreasing emergency care. Further, remote monitoring services provide an avenue for health professionals to tend to patients with chronic illnesses, which proves especially advantageous for elderly patients who often suffer how telemedicine could strengthen access to care by giving underserved areas access to physicians that are in states with higher than necessary physician-to-patient ratios); see also U.S. DEPT. OF HEALTH & HUMAN SERVS. ET AL., STATE-LEVEL PROJECTIONS OF SUPPLY AND DEMAND PRIMARY CARE PRACTITIONERS: 2013–2025, at 5 (2016), https://bit.ly/2LTbUcv (indicating a surplus of 1,230 physicians in Massachusetts and a shortage of 2,840 physicians in Texas).

69. See McCarthy, supra note 60, at 128.
70. See id.
73. See McCarthy, supra note 60, at 127 (discussing how telemedicine increases the pool of available providers).
74. See id.
75. See REPORT TO CONGRESS, supra note 56, at 4 (noting that telemedicine will provide rural communities access to specialists who are scarce in rural areas); Sahdev, supra note 2, at 1822 (discussing how telemedicine provides access to specialists who are typically sparse in rural areas). See McCarthy, supra note 60, at 129 for a discussion on how telemedicine would also provide a multitude of economic advantages to the local and metropolitan provider.
76. See Sahdev, supra note 2, at 1822 (explaining that telemedicine provides a convenient alternative for patients, thus reducing unnecessary emergency-room visits).
77. See Sahdev, supra note 2, at 1825.
from chronic illnesses and face mobility issues. The ability to conduct remote oversight decreases the need for acute medical services, which assists in driving down the cost of healthcare and expanding access to care for patients. Finally, the overall cost of telemedicine is much more affordable for patients. The average telemedicine consultation costs $49 as compared to a $145 in-person physician appointment or a $1,957 emergency room visit.

In sum, telemedicine provides numerous advantages to patients and physicians alike. The technology’s ability to reach across state borders allows for a more even distribution of provider accessibility, enhanced educational opportunities for rural physicians, and greater access to specialty services. The convenience of using telemedicine also enhances the ability of patients to receive preventative care and allows for remote oversight of chronically ill patients, easing access-to-care and cost issues for patients.

3. The Advantages and Disadvantages of Available Entity Forms

Having established how telemedicine facilitates expansive access to healthcare, this Comment now addresses how certain business entity forms can facilitate the expansion of the telemedical industry. A major premise of this Comment is that the corporate

78. See Report to Congress, supra note 56, at 4 (discussing the importance of telemedicine for elderly patients who face mobility issues); Sahdev, supra note 2, at 1824 (“Telemedicine specifically addresses the needs of elderly patients through remote monitoring of vital signs and accessibility to health professionals through virtual communications.”). As discussed above, the aging Baby Boomer population is one reason for the healthcare shortage, and thus, telemedicine directly resolves the emerging elder-care issue by providing physicians with the ability to allocate time for disease and chronic illness management. See Poma, supra note 65, at 102–04.

79. “Acute medical services,” also referred to as “acute care,” is defined as “promotive, preventive, curative, rehabilitative or palliative actions, whether oriented towards individuals or populations, whose primary purpose is to improve health and whose effectiveness largely depends on time-sensitive and, frequently, rapid intervention.” Jon Mark Hirshon et al., Health Systems and Services: The Role of Acute Care, World Health Org. (January 31, 2013), https://bit.ly/1W4AoOB [https://perma.cc/3TZL-NDFA]. Hirshon further notes that “[t]he term acute care encompasses a range of clinical health-care functions, including emergency medicine, trauma care, pre-hospital emergency care, acute care surgery, critical care, urgent care and short-term inpatient stabilization.” Id.

80. See Estimated Cost Savings, Or. Health & Scl. U., https://bit.ly/2FaVuLi [https://perma.cc/D98Y-Z44X] (noting that OHSU Telemedicine Network saved patients more than $10.6 million in transportation alone, by providing access to specialty care in their home community); Sahdev, supra note 2, at 1824–25 (noting that consistent remote oversight of patients suffering from chronic ailments helps to lower costs for patients by reducing emergency room visits).

81. See supra note 78.

82. Poma, supra note 65, at 101.
business form facilitates industry expansion. To understand how the corporate form facilitates such expansion, this section will provide a brief overview of alternative business entity forms and a discussion of the comparative advantages of the corporate form. The core distinction between each business form lies in their ability to limit personal liability of the entity’s owner(s) and to facilitate raising investment capital.

The first entity forms this Comment will examine are sole proprietorships, general partnerships, and limited partnerships. A sole proprietorship is a business where “one person owns all the business’s assets, owns all of the profits derived from its operations, and has unilateral management authority.” The sole proprietorship does not provide any degree of limited liability to the owner, and the owner bears all of the responsibilities of managing the business.

A general partnership is an entity consisting of “two or more persons [who] agree to act as co-owners of a business for profit.” General partners share equally in the business’s profits and losses and do not enjoy any degree of limited liability. Absent an agreement to the contrary, general partners also share equally in managing the business.

A limited partnership is similar to a general partnership, but it has a class of partners known as limited partners. Limited partners act as passive investors and enjoy limited liability. General

83. See infra notes 84–118 and accompanying text. This section will examine general legal principles that govern the various business forms rather than any specific state’s laws.

84. Limited liability means that the owner(s) of a business cannot be held responsible for the tortious conduct or contractual obligations of the business beyond the amount the owner has voluntarily invested. See THERESA A. GABALDON & CHRISTOPHER L. SAGERS, BUSINESS ORGANIZATIONS, 24–25 (Erwin Chemerinsky et al. eds., 2016).

85. See id. at 27–28, 38.
86. Id. at 34.
87. Id.
88. Id.
89. Id. at 35. The lack of limited liability in a general partnership makes the owners, otherwise known as partners, jointly and severally liable for all debts and obligations of the partnership. E.g., Head v. Henry Tyler Constr. Corp., 539 So. 2d 196, 197 (Ala. 1988) (“A partner of a general partnership is jointly and severally liable for all debts and obligations of the partnership.”).

90. GABALDON & SAGERS, supra note 84, at 194–95.
91. See id. 36.
92. Id. Depending on the state, limited partners may lose their limited liability “to persons who transact business with the limited partnership reasonably believing, based upon the limited partner’s conduct, that the limited partner is a general partner.” See REVISED UNIF. LTD. P’SHIP ACT § 303 (UNIF. LAW COMM’N
partners manage the business, but limited partners can vote to remove a general partner. Each of the ownership interests in the aforementioned business forms are considered relatively illiquid, which creates obstacles in raising capital for the business—such capital generally being necessary for the expansion and growth of a business. The transfer of a sole proprietor’s ownership interest is illiquid because the transferee must take on the entire business, its management operations, and the accompanying liabilities. The owner is unable to take on investments from other individuals without facing the risk of forming a default partnership.

An ownership interest in a general partnership has low liquidity because the transferee of the partnership interest receives only a right to the profits and distributions that the partnership may declare in its discretion. The transferee has no right to access partnership information or to participate in management. Only the unanimous vote of the partners will make the transferee a partner and avail the transferee to such rights. Upon being voted in as a partner, however, the transferee will be exposed to unlimited liability and will still have no right to interim distributions, although the transferee may be in a better position to effectuate his will.

An interest in a limited partnership can be illiquid largely due to the same concerns that plague general partnerships: the transfer

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1985). In other states, however, limited partners may participate in management without becoming liable for the partnership’s obligations, although they will remain liable for their own conduct. See Unif. Ltd. P’ship Act § 303 (Unif. Law Comm’n 2001) (amended 2013).

93. See Unif. Ltd. P’ship Act § 406; see also Revised Unif. Ltd. P’ship Act § 403.

94. Unif. Ltd. P’ship Act § 608; see also Revised Unif. Ltd. P’ship Act § 303 (noting that a limited partner will not lose limited liability by exercising the rights and power conferred upon them by the limited partnership agreement).

95. Id.


97. See id.


99. Revised Unif. P’ship Act § 503. The inability to participate in management or receive distributions can result in an interest holder being taken advantage of by the partners who control when distributions are made. Gabaldon & Sagers, supra note 84, at 216. Such circumstances create an issue for the interest holder because the partnership’s tax liability passes through to the interest holder in proportion to his ownership share, but the interest holder might not receive a distribution equal to the amount of his tax liability, which would thus force him to pay for such liabilities out of pocket. See, e.g., Labovitz v. Dolan, 545 N.E.2d 304 (Ill. App. Ct. 1989).

100. Revised Unif. P’ship Act § 401(i).
of a general partner’s or a limited partner’s interest will only entitle
the transferee to the interim distributions that the limited part-
nership chooses to declare.\textsuperscript{101} The transferee may be voted in as either
a limited partner or a general partner upon the unanimous consent
of the partners, provided the partnership agreement allows for such
a transfer.\textsuperscript{102}

Accordingly, except in limited circumstances, the aforemen-
tioned business forms are not particularly attractive to investors,
which can limit a business’s growth potential by depriving the busi-
ness of investors and the necessary capital for expansion.\textsuperscript{103}

Another entity form, the limited liability company (LLC),
combines the flexibility of general partnerships as a contractual en-
tity with the corporate form’s attribute of limited liability.\textsuperscript{104} LLC
interests can be highly liquid because they are easily transferable,
especially if the company is publicly traded.\textsuperscript{105}

The corporate form provides limited liability but does not offer
the same degree of flexibility in management structure and opera-
tion as LLCs.\textsuperscript{106} State statutes normally require corporations to es-
tablish a specified management structure.\textsuperscript{107} Owners of the
corporation, also known as shareholders, “lack any right of direct
involvement in the company’s management, and participate only

\textsuperscript{101}. As with the transfer of a general partnership interest, the transferee will
not have the right to access partnership information or effectuate any other rights
that attach to the original ownership interest. See \textit{Gabaldon \& Sagers, supra}
note 84, at 286. The transferee may obtain those rights only if the partners unani-
mosously consent to the transferee’s admission as a general or limited partner and
the partnership agreement allows for the transferee’s admission. \textit{Id.} Note that the
same risks associated with the lack of management rights discussed \textit{supra} note 99
are equally applicable in the context of a limited partnership. See \textit{id.} at 285–87. In
addition to those concerns, transferees of limited partnership interests may be un-
able to bring derivative actions against the partnership, which can deprive the trans-
ferree of a number of avenues for redress when faced with oppression by the
partners. See \textit{id.} at 286. If the partnership agreement does provide for freely
alienable limited partnership interests, however, barring constraints imposed by
securities laws, the interest can be highly liquid. See \textit{id.} at 285–86. Nonetheless, if
the limited partnership is a medical provider, the corporate practice of medicine
docline will still prohibit investments from non-physicians. See, e.g., 225 ILL.
COMP. STAT. 60/22.2(c) (2019) (requiring all owners of an entity that provides
medical services to be licensed medical practitioners).

\textsuperscript{102}. See \textit{Gabaldon \& Sagers, supra} note 84, at 286. Should the limited
partnership admit the transferee as a general partner, the transferee will be
exposed to unlimited liability. \textit{Id.}

\textsuperscript{103}. \textit{Zolman Cavitch, Business Organizations with Tax Planning}
§ 1.03 (2018).

\textsuperscript{104}. See \textit{Gabaldon \& Sagers, supra} note 84, at 37.

\textsuperscript{105}. \textit{Id.} at 37.

\textsuperscript{106}. \textit{Id.} at 37–38.

\textsuperscript{107}. \textit{Id.} at 37.
through their power to vote at shareholder meetings.”108 Shareholders elect the board of directors and may remove the board for cause or at will depending on the laws of the state of incorporation, the corporation’s bylaws, and the corporation’s articles of incorporation.109 The board of directors controls the policies and overarch- ing direction of the corporation and usually has the power to appoint and remove corporate officers.110 Corporate officers manage the day-to-day affairs of the corporation.111

The formal structure of a corporation often provides investors with assurances in regard to expectations of the entity’s management.112 Further, “[s]hareholders can enjoy a return on their investment either by receiving distributions of profit113 . . . or by selling shares to capture appreciation in their value.”114 Accordingly, if the company is publicly traded, corporate stock can be highly liquid.115 This liquidity, in turn, allows for ease in raising capital, which can lead to the business’s growth and expansion.116

Even though telemedicine expands access-to-care and the corporate form promotes business growth and industry expansion, the law forbids their combination.117 As discussed below, the corporate practice of medicine doctrine stands as a blockade to creating an efficient and effective healthcare system.118

B. The Current Regulatory Framework of Medicine and the Evolution of the Corporate Practice of Medicine Doctrine

The medical profession characterizes itself as one of self-regulation, but a plethora of laws, ethical requirements, and medical guides govern the doctor-patient relationship.119 Generally, state laws, through state medical licensing boards, regulate the practice

108. Id.
109. Id.
110. Id.
111. Id. at 37–38.
112. See CAVITCH, supra note 103.
113. Corporations are subject to double taxation. GABALDON & SAGERS, supra note 84, at 32. Thus, shareholders are not subject to the same tax liability risks that accompany partnerships, as described above. See id. at 38.
114. Id.
115. Id.
116. Id.
117. See infra notes 119–54 and accompanying text.
118. See infra notes 154–222 and accompanying text.
of medicine.\textsuperscript{120} Despite a long history of attempted regulation, the modern medical regulatory system is a relatively recent institution.\textsuperscript{121} Medical licensure boards came into existence in the late 19th century through the efforts of the American Medical Association (AMA).\textsuperscript{122}

In 1847, a number of doctors banded together to form the AMA to regain control over the profession from unskilled practitioners.\textsuperscript{123} The AMA lobbied state legislatures to adopt licensing laws that imposed certain requirements, which included graduating from an approved medical school and passing an independent medical examination.\textsuperscript{124} Thereafter, the AMA continued to exert influence on state licensure boards to adopt more stringent standards and reform medical education.\textsuperscript{125} Although the AMA does not retain any legal authority as a regulatory organization,\textsuperscript{126} the AMA participates in a number of regulatory groups,\textsuperscript{127} provides significant guidance in establishing accepted medical practices, and heavily influences state legislators.\textsuperscript{128}

The prohibition against the corporate practice of medicine is one example of the AMA’s ability to influence state legislators. Although the corporate practice of medicine doctrine varies among the states, the doctrine generally prohibits the following: (1) corporations and limited liability companies from employing physicians to provide medical services;\textsuperscript{129} (2) non-licensed persons or entities

\begin{footnotesize}
\begin{itemize}
\item 121. Claudio Violato, A Brief History of the Regulation of Medical Practice: Hammurabi to the National Board of Medical Examiners, 2 J. Sci. & Med. 122, 122–24.
\item 122. See id.
\item 123. Id.
\item 124. Id.
\item 125. See id.
\item 126. See Frequently Asked Questions on Ethics, Am. Med. Ass’n, https://bit.ly/2Ar2mB9 [https://perma.cc/8KKZ-9KVQ] (noting that the AMA does not have legal authority to prosecute ethics violations and that such reports should be made to state licensing boards).
\item 127. See, e.g., Liaison Committee on Medical Education, Ass’n Am. Med. Colleges, https://bit.ly/2RFw621 [https://perma.cc/NC5U-JBNN] (discussing the AMA’s role in the Liaison Committee of Medical Education, which is a subset of the U.S. Department of Education that accredits medical schools offering a Doctor of Medicine degree).
\item 128. See id.
\end{itemize}
\end{footnotesize}
from holding an ownership interest in a healthcare entity, controlling any aspect of a healthcare entity, or controlling a physician; and (3) non-licensed persons or entities from investing in or sharing in profits derived “from the physicians’ provision of medical services.”

The corporate practice of medicine doctrine came into existence as a result of the AMA’s desire to retain professional autonomy, the AMA’s concern that corporate involvement would create a “‘spirit of trade’” within the profession, and the AMA’s fear that lay control over medical professionals would degrade quality of care. The AMA’s concerns permeated the U.S. legal system, resonating in various court decisions as “public policy concerns.” Courts and state attorneys general (AGs) created a ban on the corporate practice of medicine through the interpretation of state medical practice acts and medical licensure laws. Many medical practice acts prohibit the practice of medicine by a “person” without a valid license. Courts and AGs have found that the use of health care professionals by business entities or nonprofessionals absent legislative authorization.


133. Id. at 702–04.


136. E.g., KAN. STAT. ANN. § 65-2803 (2018); see also Freiman, supra note 16, at 704.
the word “person” in these statutes means a “human being.” Accordingly, “[b]ecause the acts of a corporation’s employees are attributed to the corporation,” a corporation’s employment of a physician would violate state medical licensure provisions. Other state authorities have used a similar rationale in ruling that corporations are prohibited from practicing medicine, but have focused on the education requirements underlying the state’s licensure laws and determined that the corporation, as a “legal fiction,” is unable to meet such requirements and obtain a license.

The central focus of the doctrine’s promulgation, however, lies in public policy. Courts often rely on the three following policy considerations: “1) commercial exploitation and a lowering of professional standards stemming from the overriding profit motive of corporations; 2) the division of the physician’s loyalty between the best interests of the patient and profit-making; and 3) lay control of medical decisions by corporate managers over professional medical judgment.”


139. See, e.g., infra note 147. Some authorities have also based the corporate prohibition on state statutes prohibiting fee splitting. See Lofft et al., supra note 129, at 13, and others on state statutes that specifically allow professional corporations, hospitals, and other entities to practice medicine but do not mention general corporations. E.g., Ark. Op Att’y Gen. No. 94-204, 1994 WL 481180 (Aug. 17, 1994). Finally, other states explicitly prohibit corporate practice by statute. See COLO. REV. STAT. 12-36-134 (2018) (prohibiting general corporations from practicing medicine and lay persons from being stockholder or directors of a medical corporation).

140. Id. at 706.

141. Id. (citing Alanson W. Wilcox, Hospitals and the Corporate Practice of Medicine, 45 CORNELL L.Q. 432, 442–43 (1960); Jeffrey F. Chase-Lubitz, Note, The Corporate Practice of Medicine Doctrine: An Anachronism in the Modern Health Care Industry, 40 VAND. L. REV. 445, 467 (1987)); e.g., Spine Imaging MRI, L.L.C. v. Country Cas. Ins., No. 10-480 (JRT/ALB), 2011 WL 379100, at *8 (D. Minn. Feb. 1, 2011) (noting that a policy rationale for the doctrine is to ensure independent medical judgment); Bartron v. Codington Cty., 2 N.W.2d 337, 346 (S.D. 1942) (discussing that the practice of a medicine by a for-profit corporation through licensed individuals “debas[es] the profession” and subjects the profession to commercial exploitation); Isles Wellness, Inc. v. Progressive N. Ins., 725 N.W.2d 90, 93 (Minn. 2006) (“[T]he public policy considerations in applying the corporate practice of medicine doctrine are ‘concerns raised by the specter of lay control over professional judgment, commercial exploitation of health care practice, and the possibility that a health care practitioner’s loyalty to a patient and an employer will
Nonetheless, exceptions to the corporate practice of medicine doctrine exist. Non-profit corporations are often exempt from the prohibition because profits are not the entity’s motivation; thus, the concern that the corporation will prioritize profit above quality does not apply.\footnote{142} A second exception that all states provide is the professional corporation, which states often require to be entirely owned and managed by licensed members of the medical profession.\footnote{143} Finally, many states exempt Health Maintenance Organizations (HMOs)\footnote{144} and, in some instances, hospitals.\footnote{145}

The existence and enforcement of the corporate practice of medicine doctrine also varies dramatically from state to state.\footnote{146} A 2006 survey indicated that 29 states prohibit the corporate practice of medicine via statute, case law, or AG opinion.\footnote{147} Four states exist in conflict.”‘ (quoting Isles Wellness, Inc. v. Progressive N. Ins., 703 N.W.2d 513, 517 (Minn. 2005)).

\footnote{142. Id. at 706–07; e.g., Grp. Health Ass’n v. Moor, 24 F. Supp. 445, 446 (D.D.C. 1938) (finding that actions of nonprofit associations are not the practice of medicine). But see Cal. Physicians’ Serv. v. Aoki Diabetes Research Inst., 78 Cal. Rptr. 3d 646, 653 (Ct. App. 2008) (noting that nonprofits are not categorically outside the corporate practice of medicine ban).

\footnote{143. Id. at 707; e.g., NEV. REV. STAT. § 89.050 (2018); Columbia Physical Therapy, Inc., P.S. v. Benton Franklin Orthopedic Assoc., P.L.L.C., 228 P.3d 1260, 1265–66 (Wash. 2010) (noting that the professional corporation is exempt from the prohibition of the corporate practice of medicine); Estate of Harper v. Denver Health & Hosp. Auth., 140 P.3d 273, 276 (Colo. App. 2006) (“[P]hysicians may be employed by . . . professional service corporations owned by physicians . . . .”).

\footnote{144. E.g., Isles Wellness, Inc. v. Progressive N. Ins. Co., 703 N.W.2d 513, 518 (Minn. 2005) (recognizing that HMOs are exempt from the corporate practice prohibition); see Freiman, supra note 16, at 707. This Comment references HMOs only to give a complete understanding of how the corporate practice of medicine doctrine has come to exist and function in the modern healthcare climate. Although HMOs underscore how illogical the doctrine is, they are beyond the scope of this Comment.


\footnote{146. See Freiman, supra note 16, at 713.

\footnote{147. See MARY H. MICHAL ET AL., CORPORATE PRACTICE OF MEDICINE DOCTRINE: 50 STATE SURVEY SUMMARY 1–16 (2006), https://bit.ly/2RC1YQ0 [https://perma.cc/S6PE-QXRK] (AZ, ARK, CA, CO, CN, FL, GA, ID, IL, KA, KY, MD, MA, MI, MN, NV, NJ, NY, NC, ND, OR, PA, SC, SD, TX, WA, WV, WI). Michal et al. list Delaware as having no guidance on the matter, however, upon review of the laws of the 50 states, Delaware can be added to the list of those states prohibiting the corporate practice of medicine based on AG opinion. Delaware’s AG has interpreted Delaware’s statutory licensure and educational requirements as prohibiting the corporate practice of optometry except when done as a professional service corporation because a corporation cannot obtain an education or meet certain other statutory requirements to obtain a license. Del. Op. Atty. Gen. No. 85-1011, 1985 WL 165944 (June 18, 1985). Although the AG’s opinion
pressly allow the corporate practice of medicine by case law or statute.148 Fourteen states and the District of Columbia allow the corporate practice of medicine by either AG opinion or absence of law on the matter, and thereby subjects those states to the whims of the judiciary and future AGs.149 In the remaining three states—Indiana, Ohio, and Oklahoma—it is unclear whether the corporate practice of medicine is prohibited due to AG or judicial opinions conflicting with regulations.150

States that do prohibit the corporate practice of medicine charge the AG with enforcing the doctrine.151 Because the priorities of each state’s AG may differ, enforcement of the doctrine varies widely among states.152 Some states enforce the doctrine strictly, others sporadically, and others not at all.153 Accordingly, this sporadic and varying enforcement creates a great deal of uncertainty for entrepreneurs who seek to create corporations that provide medical services.154

III. Analysis

A. Overview

States can alleviate the tension between healthcare marketplace efficiency and healthcare quality by abandoning the corporate practice of medicine doctrine in the specific context of telemedicine. Commentators have questioned whether the corpo-

148. See Michal et al., supra note 147, at 1–16 (NE, TN, UT). Upon review of the laws of the 50 states, Alaska can be added to the list of those states that expressly allow the corporate practice of medicine. See A.A. Pain Clinic, Inc. v. Sisters of Providence in Wash., No. 3AN-S98-4312 CI, 1998 WL 35151315, at *1 (Alaska Super. Ct. Jan. 1, 1998) (denying defendant’s argument that corporation did not have standing to sue based on the theory that corporation cannot practice medicine, and recognizing that corporations may operate businesses that require licenses, including medicine, through the corporation’s properly licensed agents).

149. See Michal et al., supra note 147, at 1–16 (AL, DC, HI, IA, LA, ME, MS, MO, MT, NH, NM, RI, VT, VA, WY).

150. See id. at 12.

151. E.g., Trier v. Aspen Dental Mgmt., 94 F. Supp. 3d 352, 361–62 (N.D.N.Y. 2015) (discussing that the attorney general is responsible for enforcing the corporate practice of medicine doctrine in New York); People v. United Med. Serv., 200 N.E. 157, 159 (Ill. 1936) (noting that state law authorizes the attorney general to bring an action against corporations that “exercise[ ] powers not conferred by law”); see also Freiman, supra note 16, at 698.


153. Id. at 713.

154. Id. at 698.
rate practice of medicine doctrine meets its purpose in the modern healthcare climate. Although many scholars have advocated for abandoning the doctrine, a few remain steadfast in the belief that corporate practice is an evil that states must continue to proscribe. Each of the doctrine’s policy arguments coalesce into one central theme: the need to ensure quality patient care. The arguments for bolstered state enforcement of the doctrine presume that a profit-making motive results in the degradation of quality of care, and that unlike corporations, physicians are free from any profit-making influence when they treat patients. Accordingly, this Comment will address the arguments advanced by advocates of the doctrine through a quality-of-care-focused framework. The final policy rationale advanced in support of the doctrine, the need for


156. See Huberfeld, supra note 130, at 244 (“The corporate practice of medicine doctrine is a relic; a physician-centric guild doctrine that is at best misplaced, and at worst obstructive, in the present incarnation of the American health care system.”); Lisa Rediger Hayward, Note and Comment, Revising Washington’s Corporate Practice of Medicine Doctrine, 71 WASH. L. REV. 403, 428 (1996) (arguing for limiting the doctrine due to a multitude of factors in the modern healthcare environment that ensure quality of care, while recognizing the need for continued assurances that lay control over physician autonomy would be prohibited); Chase-Lubitz, supra note 141, at 488 (“This prohibition threatens the development of nontraditional health care delivery systems in many states. For innovation of delivery systems to continue, state courts and legislatures should modify corporate practice prohibitions to reflect current views on physician autonomy and the role of commercialism in medicine.”).

157. See Andre Hampton, Resurrection of the Prohibition on the Corporate Practice of Medicine: Teaching Old Dogma New Tricks, 66 U. CIN. L. REV. 489, 492 (1998) (arguing for the resurrection of the corporate practice of medicine doctrine to reduce conflicts of interest between insurers and medical professionals); Ewell, supra note 2, at 75 (arguing for revitalized enforcement of the corporate practice of medicine doctrine in the context of telemedicine to ensure quality of care in Internet medicine).

158. See State Farm Mut. Auto. Ins. Co. v. Mallela, 372 F.3d 500, 503 (2d Cir. 2004) (noting that the state’s concern in prohibiting the corporate practice of medicine was to ensure that the quality of care afforded to patients was not undermined.); Cal. Physicians’ Serv. v. Aoki Diabetes Research Inst., 78 Cal. Rptr. 3d 646, 654 (Ct. App. 2008) (“The ban on the corporate practice of medicine is meant to protect patients . . . .”); Isles Wellness, Inc. v. Progressive N. Ins. Co., 725 N.W.2d 90, 95 (Minn. 2006) (noting the purpose of the doctrine is to protect patients).

159. Freiman, supra note 16, at 706. As noted above, courts have identified various public policy considerations underlying the doctrine, such as preventing “commercial exploitation and a lowering of professional standards stemming from the overriding profit motive of corporations . . . [and preventing] the division of the physician’s loyalty between the best interests of the patient and profit-making.” Freiman, supra note 16, at 706
physicians to be free from lay influence,\textsuperscript{160} has been explored thoroughly in other works\textsuperscript{161} and will not be addressed here.

\textbf{B. Reasons for Eliminating the Corporate Practice of Medicine Doctrine}

This Comment advances four reasons for eliminating the corporate practice of medicine doctrine: (1) profit-making motives are prevalent in the current healthcare industry and do not degrade quality of care; (2) the doctrine chills the proliferation and expansion of the telemedical industry and thus impedes access-to-care; (3) the doctrine limits the causes of action that injured patients may pursue against providers who furnish substandard care; (4) litigation risks, including class-action lawsuits, mitigate any residual risks associated with abandoning the doctrine.

\textbf{1. Continued Prevalence of Profit-Based Decision-Making and Its Non-Correlation with Substandard Care}

Courts and empirical studies alike have concluded that profit-making motives influence physicians in treating patients.\textsuperscript{162} Evidence as to whether a doctor’s profit-making motive has caused injury, however, is inconclusive.\textsuperscript{163} Indeed, commentators have indicated that a physician’s profit-making motive may be beneficial in some instances.\textsuperscript{164} The Institute of Medicine has even advocated for utilizing the physician’s profit-making motive to ensure increased quality in patient care.\textsuperscript{165} By aligning a provider’s profits

\textsuperscript{160.} See Freiman, \textit{supra} note 16, at 702–04.


\textsuperscript{162.} See \textit{Isles Wellness, Inc.}, 703 N.W.2d at 524 (agreeing that physicians are not free from fiscal influence in decision-making); \textsc{Martin & Neville}, \textit{supra} note 161, at 20 (noting that profits influence physicians); Huberfeld, \textit{supra} note 130, at 245 (“Also, in this era of managed care reimbursement, where physicians are forced to bear the risk of providing patients too much time or too many services, the time has come to realize and accept that physicians are, in fact, influenced by financial gain (or loss).”).

\textsuperscript{163.} \textsc{Martin & Neville}, \textit{supra} note 161, at 21 (“What remains unclear is the extent to which patients were harmed—or in some cases, perhaps even helped—as a result of [physician profit motivated decision-making] bias.”).

\textsuperscript{164.} \textit{Id.} (“[I]t is possible that, even if financial relationships are changing physician behaviors, they are changing them for the better in certain situations.”).

\textsuperscript{165.} See Huberfeld, \textit{supra} note 130, at 269–70 (“The IOM makes a strong point that current payment policies should be wholly revised to positively influence health care providers to ‘align[ ] . . . payment incentives with quality improve-
with a physician’s ability to render effective care, patients would reap not only the benefits of increased quality and efficiency of care but also increased access to care.166

Similar to the Institute of Medicine’s theory, a corporation’s profit-making motive can ensure increased quality and efficiency in care. The corporation’s profit-making motive would require the entity to (1) search for efficient solutions to patient problems,167 (2) utilize preventative-care measures, and (3) ensure the highest quality of care to earn the most profits,168 while avoiding liability exposure that could be detrimental to profits.169

Moreover, scholars alleging that corporate involvement would degrade quality of care have failed to provide any data to support their conclusion and often couch their arguments in theory and speculation.170 The available data suggests the opposite: “allowing

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166. See id. (tracing how the corporatization of healthcare creates a synergy between business and health professionals that ultimately benefits patients).
167. See id. at 276–77 (discussing efficiency in medicine by removing the corporate practice of medicine doctrine).
168. See id. at 505–06.  Id at 505–06.  Under the fee-for-service

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doctors to contract for employment with corporate entities increases access to care without diminishing the quality of that care.” 171 Thus, the first two premises of the doctrine, that a corporation’s profit-making motive will degrade quality of care and that physicians are free from any profit-making motive, are invalid.

2. The Doctrine Chills the Proliferation of Telemedicine and Consequently, Access to Care

As discussed above, telemedicine provides an avenue for alleviating healthcare costs and expanding access to healthcare through the use of telecommunications technology. 172 By using corporations as a vehicle for business growth and industry expansion, states and entrepreneurs can make telemedicine more widely accessible to a variety of populations. Further, increased competition in the telemedical industry will force care providers to create more efficient and innovative solutions to drive down costs for customers and increase profits for shareholders. 173

Although the doctrine is either non-existent or unenforced in many states, the doctrine may nonetheless create a chilling effect on individuals seeking to enter the telemedicine industry. 174 Courts and commentators alike recognize that unenforced laws can create a chilling effect on behavior. 175 For example, the regulation of ma-
Dr. Tele-Corporation

marijuana under the Obama Administration proves an analogous point concerning the chilling effect that unenforced laws can have on a business. As of the time of this writing, marijuana is illegal under federal law, but several states have legalized the substance for medicinal and recreational use.176 Although the Obama Administration indicated that it would not prosecute marijuana distributors operating in accordance with state law,177 a number of banks and other ancillary businesses refused to conduct business with marijuana distributors because the federal government could deem the distributor’s proceeds illegal or create other operational difficulties.178 Accordingly, although unenforced under federal law and legal under state law, the risks associated with entering the marijuana industry has created hesitation amongst a number of entrepreneurs.179 Thus, even if certain states do not enforce the corporate practice of medicine doctrine, the doctrine likely creates a chilling effect on entrepreneurs seeking to enter the industry.

The corporate practice of medicine doctrine significantly limits technology’s ability to provide expansive access to care by prohibiting corporate entities from engaging in the telemedical industry.180 Allowing corporations to engage in marketplace competition will force providers to find safe, innovative, and economic solutions to patient care problems.181 Further, corporate entities will likely seek

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179. See id.
180. Robertson, supra note 171, at 197 (“[E]xperience has shown that allowing physicians to practice in ‘efficient and economical’ business forms improves access to medical care for individuals, especially in rural or remote areas where the fixed costs of practice may not allow a single doctor’s practice to scale to an efficient level.”) (citing Michelle Gustavson & Nick Taylor, At Death’s Door—Idaho’s Corporate Practice of Medicine Doctrine, 47 IDAHO L. REV. 479, 518 (2011)). As detailed above, high cost of care is one factor that results in decreased access, which telemedicine alleviates. See supra notes 49–82 and accompanying text.
to capture as much of the market as possible to create the largest gains possible. With the rural population being a largely untapped market, corporations will likely seek to expand into rural sectors.

3. The Doctrine Fails to Prevent Corporate Involvement and Limits Actions Against Corporate Defendants

Although the doctrine chills corporate involvement in the medical and telemedical industry, the doctrine fails to entirely eradicate such involvement. Corporations simply construct a work-around to prevent any allegation that the entity is functioning in violation of the corporate practice of medicine doctrine. One way entities circumvent the doctrine is by structuring the relationship between itself and the provider as an independent contractor arrangement. The independent contractor arrangement limits the form and number of causes of action an aggrieved patient may pursue against a telemedical corporation or LLC. This section addresses the causes of action a patient may pursue upon injury by a telemedical provider.

182. William C. Beckwith, Comment, Cutting the Cord: Removing the CMRS Spectrum Cap to Promote Wireless-Landline Convergence and Wireless Alternatives in the Local Loop, 7 COMM.LAW CONSPECTUS 369, 386 (1999) (discussing that deregulation in the phone industry will cause service providers to move into unserved rural areas for profit gain).

183. As discussed above, rural populations have an access-to-care dilemma, which telemedicine seeks to alleviate. See REPORT TO CONGRESS, supra note 56.

184. See sources cited supra note 180.

185. MARTIN & NEVILLE, supra note 161, at 4.

186. See id. at 14–19.

187. See, e.g., Conrad v. Med. Bd., 55 Cal. Rptr. 2d 901, 907–08 (Ct. App. 1996) (discussing use of independent contractor arrangement to circumvent corporate practice of medicine doctrine); Doctor on Demand Terms of Use, DOCTOR ON DEMAND ¶ 19 [hereinafter DD Terms of Use], https://bit.ly/2CS9t71 [https://perma.cc/KWX2-96ED]. Hospitals and other entities also utilize a number of other workarounds. See Kim, supra note 171, at 21 (discussing that hospital administrators use a number of strategies to circumvent the corporate practice of medicine doctrine).

188. See infra notes 197–209 and accompanying text; see also Daly v. Aspen Ctr. for Women’s Health, Inc., 134 P.3d 450, 452 (Colo. App. 2005) (discussing that the prohibition on corporate practice of medicine bars entity liability for malpractice); Estate of Harper v. Denver Health & Hosp. Auth., 140 P.3d 273, 275–76 (Colo. App. 2006) (noting that the entity could not be held liable because it could not practice medicine under the corporate practice of medicine doctrine).
a. Malpractice Action Against the Doctor

The first cause of action an injured patient may pursue is medical malpractice against the doctor. To establish a claim for medical malpractice, the plaintiff must satisfy the same elements of a traditional negligence claim: (1) the doctor owed a duty of care to the plaintiff; (2) the doctor breached his duty; (3) the breach was the proximate cause of harm to the plaintiff; and (4) the damages suffered by the plaintiff were a direct result of the harm. To demonstrate that the doctor owed a duty of care to the plaintiff, the plaintiff must only show that a doctor-patient relationship existed. The customs of the profession determine the duty of care owed to a patient; however, a physician must generally exercise the “degree of care, skill, and proficiency exercised by [a] reasonably careful, skillful, and prudent practitioner[ ] in the same class to which the physician belongs, acting under the same or similar circumstances.” To demonstrate that the doctor breached his duty, the plaintiff must show through expert testimony that the doctor departed from the set standard of care. Lastly, the plaintiff must show that the doctor’s breach of duty caused the plaintiff’s injury in law and fact. Upon establishing each of the requisite elements, the plaintiff may recover damages from the doctor.

b. Causes of Action Against a Corporation or LLC

An individual who is injured by an employee of a business can usually hold the employer vicariously liable for the actions of its

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189. Medical malpractice is only one cause of action that a harmed patient may pursue against a doctor, or as discussed below, an entity. Depending on the factual circumstances of the case, breach of contract, fraud, RICO, and other actions may be viable claims as well. See Richard A. Epstein & Alan O. Sykes, The Assault on Managed Care: Vicarious Liability, ERISA Preemption, and Class Actions, 30 J. LEGAL STUD. 625, 654–59 (2001) (discussing various forms of liability that plaintiff attorneys pursue against entities).


194. Whyde, 659 N.E.2d at 627.

195. Id.

196. See, e.g., Nestlehutt v. Atlanta Oculoplastic Surgery, No. 2007EV002222-J, 2009 WL 348361 (Ga. State Ct. Feb. 9, 2009) (discussing various forms of damages available in malpractice actions, and noting that plaintiffs were awarded damages after proving their medical malpractice claim).
employee. A cause of action under a respondeat superior theory of liability requires proof of each of the elements against the employee, with the additional proof that the employee was acting within the scope of his employment when he caused the injury.

It must be kept in mind, however, that employers are liable only for the acts of employees. Generally, employers are not liable for the torts of independent contractors. Nonetheless, an employer can be liable for the torts of an independent contractor under various theories of direct liability.

One potential form of direct liability that a plaintiff can attribute to a telemedical provider is negligent hiring or retention. A cause of action for negligent hiring or retention requires the same proof as that required for a traditional cause of action sounding in negligence. Breach of duty takes into account a variety of factual considerations, including the independent contractor’s reputation and the necessary expertise and competencies required for the job.

c. The Advantages of Pursuing Entity Liability and the Attaching Deterrent Effect

Commentators have noted that entity liability is a more pragmatic solution than holding a doctor individually liable. First, the entity is usually better situated to handle the costs of litigation and...
better able to pay damages. Moreover, entities are often liable as a matter of respondeat superior because they are better situated to prevent injuries caused by their employees by requiring employees to comply with certain policies and procedures.

Accordingly, should lay control result in injury, the corporate medical provider would be subject to suit. Upon suffering the repercussions of a successful lawsuit, the provider would reform or continue to suffer similar lawsuits. Analysts have concluded in a similar context that hospitals, as corporations for which states often provide an exemption from the corporate practice prohibition, would be more efficient at delivering and promoting high-quality care if they were the ones held liable for medical malpractice. Thus, by forcing an independent contractor relationship, the corporate practice of medicine doctrine deprives harmed patients of the ability to pursue an entity theory of liability, and thereby deprives society of the positive externality of effective malpractice deterrence.

4. Vulnerability to Widespread Litigation Mitigates Residual Risks That May Accompany Abandoning the Doctrine

Litigation, including class-action lawsuits, would mitigate the doctrine’s underlying public policy concern that a corporation’s profit-making motive will result in a degradation of quality of care.

205. Patterson v. Blair, 172 S.W.3d 361, 364 (Ky. 2005) (citing Richard A. Posner, Economic Analysis of Law 204–05 (5th ed. 1998) (noting that one of the justifications for respondeat superior is the employer’s ability to afford compensating victims, which is also known as the “deep-pocket” argument for liability).

206. Id. (suggesting that the sounder rationale for respondeat superior is that employers are better able to enforce tort law against employees through threat of termination, which causes employees to be more responsive to tort law than they would be otherwise).

207. Barry R. Furrow, The Patient Injury Epidemic: Medical Malpractice Litigation as a Curative Tool, 4 Drexel L. Rev. 41, 54 (2011) (noting that law suits are powerful deterrents that impact the behavior of healthcare providers. Any objection to such an approach on the grounds of needing to address pre-injury quality of care risks can be quickly dismissed. A number of accreditation and governmental authorities regulate quality of care by ensuring organizational policies and procedures are in compliance with current minimum standard of care protocols. See Huberfeld, supra note 130, at 272–75. Such authorities would act with equal force to any corporate telemedical entity. See id.


209. See Huberfeld, supra note 130, at 273 (“The American Law Institute historically has suggested that exclusive hospital liability would be more efficient and promote quality better when a physician negligently causes medical injury in a hospital . . . .”). See Gatter, supra note 170, at 248–55 for a discussion on the issues and critiques of the current medical malpractice system.
The basic requirements for a class-action lawsuit are numerosity, commonality, typicality, and adequacy of representation.\textsuperscript{210} Telemedicine’s ability to provide expansive access to care and to reach a theoretically unlimited number of patients—and thereby a theoretically unlimited amount of profit—places telemedical providers in a business model that is susceptible to the numerosity requirement.\textsuperscript{211} Corporations, and business entities generally, are also more easily able to satisfy the numerosity requirement than individuals because a larger number of harms or wrongs can be attributed to the entity as opposed to a single person.\textsuperscript{212}

\textsuperscript{210} Gen. Tel. Co. of the Sw. v. Falcon, 457 U.S. 147, 156 (1982). A putative class must also be of the type maintainable under Rule 23(b) of the Federal Rules of Civil Procedure. See \textit{Fed. R. Civ. P. 23}. Because a class action of the nature discussed here would seek money damages, Rule 23(b)(3) would be the most likely section through which class-counsel could maintain an action against a telemedical entity. See Day v. NLO, 851 F. Supp. 869, 885–86 (S.D. Ohio 1994). Rule (b)(3) certification is the preferred route when monetary damages are the plaintiffs’ primary goal. \textit{Id.} Rule 23(b)(3) requires for a common question to predominate over any individual questions and for a class action to be superior to other methods of adjudication. See \textit{Fed. R. Civ. P. 23(b)(3)}. A detailed discussion of 23(b) is not warranted for purposes of this Comment. The purpose of this section is not to detail every circumstance in which an action may or may not receive class-certification, but rather to illuminate three overarching points: (1) class-action lawsuits are a pronounced risk for telemedical corporations; (2) class actions or the threat thereof are one viable method of redressing the concerns that proponents of the doctrine tout, if or when those concerns arise; and (3) the repercussions of threatened or actual class actions are against a corporation’s purported sole interest in “the bottom-line.”

\textsuperscript{211} See Marcus v. BMW of N. Am., LLC, 687 F.3d 583, 594 (3d Cir. 2012) (noting that numerosity requires a class to be “so numerous that joinder of all members is impracticable”) (quoting \textit{Fed. R. Civ. P. 23(a)(1)}); see, e.g., Kutschbach v. Davies, 885 F. Supp. 1079, 1084 (S.D. Ohio 1995) (finding that joinder was impracticable because class members numbered in the hundreds and were scattered across Ohio); Mathis v. Bess, 138 F.R.D. 390, 393 (S.D.N.Y. 1991) (noting that class satisfied the numerosity requirement solely based on the fact that the class had 120 members); Alvarado Partners, L.P. v. Mehta, 130 F.R.D. 673, 675 (D. Colo. 1990) (finding that joinder was impracticable because 33 class members were dispersed throughout the country); Moskowitz v. Lopp, 128 F.R.D. 624, 628 (E.D. Pa. 1989) (finding a class satisfied numerosity because the class numbered in the thousands); Riordan v. Smith Barney, 113 F.R.D. 60, 62 (N.D. Ill. 1986) (noting that numbers alone are dispositive if class is large enough).

\textsuperscript{212} See Christine P. Bartholomew, \textit{Redefining Prey and Predator in Class Actions}, 80 \textit{Brook. L. Rev.} 743 (2015), for a discussion on perceived corporate vulnerability to class-action lawsuits. The corporation’s and the telemedical industry’s susceptibility to numerosity is the key risk factor that mitigates against any negative externality of abandoning the corporate practice of medicine doctrine. Proponents of the doctrine may argue that law suits designed to redress quality of care issues, such as medical malpractice claims, are unlikely to receive class certification because of the individualized nature of such claims. See Epstein & Sykes, \textit{supra} note 189, at 653–54 (discussing that class actions are often not viable mechanisms for medical malpractice claims). Although, as discussed below, policy-based suits have a higher probability of certification, the proponent’s argument regarding
A plaintiff can establish commonality by demonstrating that the class members’ claims would be resolved upon a determination of whether the corporation had a policy in place or a pattern and practice of conduct that led to the alleged harm.213 Similarly, a plaintiff can establish typicality by demonstrating that claims of “the class and the class representative arise from the same event or pattern or practice and are based on the same legal theory.”214 A plaintiff-representative could utilize an entity theory of liability centered on the corporate telemedical provider’s pattern and practice or systemic policy of disregarding care for profits to meet the com-

213. See Walmart Stores, Inc. v. Dukes, 564 U.S. 338, 350 (2011) (noting that class members’ claims “must depend upon a common contention . . . of such a nature that it is capable of class wide resolution—which means that determination of its truth or falsity will resolve an issue that is central to the validity of each . . . claim in one stroke.”); see, e.g., Romano v. SLS Residential Inc., 246 F.R.D. 432, 444–47 (S.D.N.Y. 2007) (certifying class action on a policy based theory).

monality and typicality prongs. Adequacy of representation simply requires choosing a plaintiff-representative who does not have a conflict of interest with other class members and who will prosecute the action vigorously.

Should a putative class institute an action against a corporate telemedical provider, the suit would expose the corporation to a considerable amount of financial risk due to the high awards of damages that often accompany class-action lawsuits. The corporation would also suffer a considerable amount of reputational damage. Moreover, even when class certification is debatable, the mere threat of a class action can have a deterring effect because such actions expose companies to the same reputational concerns, which may catalyze behavioral reforms and result in a company settling to avoid costs associated with trial. Should a court deny class certification, widespread litigation would still force the corporation to confront the same risks associated with class actions.

Finally, if the cost of litigation passes to the customers, the company would likely begin to lose business as customers choose new service providers with lower prices. The loss of clientele is especially pronounced in the telemedical context because of the ease with which consumers may obtain a new provider due to the consumer being free from the constraints of a physical market-

215. See, e.g., Romano, 246 F.R.D. at 444–47 (certifying class upon finding that plaintiffs alleged a pattern and practice theory of liability against the entity, which satisfied commonality and typicality requirements).


217. See Russell M. Gold, Compensation’s Role in Deterrence, 91 Notre Dame L. Rev. 1997, 1999–2000 (2016). The above argument demonstrates that even accepting the underlying rationale of the doctrine—that a corporation will sacrifice quality of care for increased profits—such corporate conduct would not align with the corporation’s profit-making motive.

218. See id.; see also JAMES RUBIN & B ARIE CARMICHAEL, RESET: BUSINESS AND SOCIETY IN THE NEW SOCIAL LANDSCAPE 161–92 (2018) (discussing the repercussive force of reputational damage for businesses, including in the context of class actions for medical-care related injuries, and identifying its ability to cause businesses to suffer financial losses and catalyze internal reform).

219. See Rubin & Carmichael, supra note 218, at 168–74; see also In re Rhone-Poulenc Rorer, Inc., 51 F.3d 1293, 1299 (7th Cir. 1995) (noting that class actions place pressure on defendants to settle).

220. See supra note 212.

221. See, e.g., DAN B. DOBBS ET. AL., TORTS AND COMPENSATION PERSONAL ACCOUNTABILITY AND SOCIAL RESPONSIBILITY FOR INJURY 698–99 (7th ed. 2013) (noting that when manufacturers are sued for a defective product, they will increase the product’s price to cover the costs of liability, those costs will be passed on to consumers, and the consumer will then seek out cheaper substitutes, which will usually be safer because the substitute manufacturer will not have had to impose liability costs on the consumer).
Thus, the corporation that sacrifices patient quality of care for potential profit will have two options: reform its business model and seek innovative ethical solutions for the efficient delivery of care, or fail.

IV. CONCLUSION

The corporate practice of medicine doctrine stems from a flawed policy rationale that does not take into account the current state of the healthcare marketplace. Advocates of the doctrine have failed to provide any data that demonstrates corporate involvement degrades quality of care. Even accepting the premise that the profit-making motive of the corporation will predominate over any other concerns, sacrificing quality of care for efficiency would not align with a corporation’s profit-making motive. Telemedicine’s ability to expand access to care, however, is based on well-founded statistical data. States, together with entrepreneurs, can significantly alleviate the access-to-care issue by combining the corporate entity’s ability to expand industries and telemedicine’s ability to expand access to care. On balance, considering that class-action lawsuits or widespread litigation would mitigate any degradation in quality of care resulting from corporate involvement, and the fact that data is at best speculative on whether such involvement will impact quality of care, the corporate entity’s ability to expand the telemedical industry and provide comprehensive access to care outweighs any residual risk posed by abandoning the corporate practice of medicine doctrine. To expand access to healthcare and drive healthcare costs down, states should abandon the corporate practice of medicine doctrine at least for the specific context of telemedicine.

222. See, e.g., Eric Wicklund, In a Competitive Market, Telehealth Can Be a Valuable Commodity, mHEALTH INTELLIGENCE (May 18, 2018), https://bit.ly/2iVJUCs [https://perma.cc/C9EE-24VJ] (discussing UPMC Pinnacle’s ability to serve former Penn State Health Milton S. Hershey Medical Center patients through use of telemedicine and noting that telemedicine allows consumers to “shop around” when providers are not meeting patient demand and expectations).