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GROUP HEALTH PLANS: SOME LEGAL AND ECONOMIC ASPECTS

THE inadequate distribution of the nation's medical resources, long a subject of widespread complaint, has been accentuated by war exigencies. With over one-third of the country's physicians in the armed services¹ and a rapid concentration of families in defense areas lacking proper health facilities,² fuller utilization of civilian medical personnel and equipment has become a critical need. To that end, peacetime experimentation with more efficient forms of distributing medical care should be carried on with renewed vigor. Yet this experimentation is seriously obstructed by the intransigent opposition of vested interests rooted in the whole organization of modern medical practice—an opposition facilitated by the interaction of inept legislative and judicial controls and the sentimental attachment of the medical profession to traditional ways of furnishing service. Elimination of these impediments awaits recognition that arrangements for distributing service are not ends in themselves but instruments whose value depends upon how well they perform their function of maintaining the nation's health.

1. See *Report of the Committee on Medical Preparedness* (1942) 119 J. AMER. MED. ASS'N 650; Davis, *The Supply of Doctors* (1942) 2 MEDICAL CARE 314; (1943) 3 MEDICAL CARE 59.

2. See *OWI Implies Need of Action to Avert Medical Crisis* (1943) 20 MEDICAL ECONOMICS 44; (1943) 3 MEDICAL CARE 51.

THE ECONOMICS OF GROUP HEALTH

Inability to pay for the increasing cost of good medical service has appeared, time and again, as the primary cause of the inadequate treatment received by the great bulk of the population.³ The expensive technical equipment and specialized training requisite to modern medical practice,⁴ coupled with the uneven and unpredictable way sickness falls, have increased the financial burden of illness beyond the means of most families.⁵ And medical personnel and facilities, under the influence of the system of competitive enterprise, have followed ability to pay rather than need, with the result that not only is there geographic overconcentration of resources in cities and wealthier states with concomitant undersupply in poorer regions,⁶ but receipt of treatment generally varies in quantity and quality with income.⁷ Thus, close to one-third of the nation's physicians remain idle almost one-third of their potential working time, while the poorer half of the population receives less than half the medical attention it needs.⁸

The problem of medical maldistribution has been attacked from the standpoint of both the producer and the consumer of medical service. Physicians, on the one hand, have combined to practice as a group in systematic association instead of on the traditional individual practice basis.⁹ Substantial economies are realized by such group practice through joint utilization of expensive technical facilities and personnel. More significantly, professional efficiency also results from coordination of practitioners possessing differentiated skills and using highly specialized equipment. And finally, physicians working as a group acquire greater financial stability as well as contacts and facilities for professional advancement.

Consumers, on the other hand, have also organized, in order to protect themselves against the uncertain occurrence of sickness,¹⁰ through group pre-

3. See generally COMMITTEE ON THE COST OF MEDICAL CARE, *MEDICAL CARE FOR THE AMERICAN PEOPLE* (1932).

4. See CABOT, *THE PATIENT'S DILEMMA* (1940) 13-19.

5. See FALK, ROEM, AND RING, *THE COSTS OF MEDICAL CARE* (1932) 135-54.

6. See PEEBLES, *A SURVEY OF STATISTICAL DATA ON MEDICAL FACILITIES IN THE UNITED STATES* (1929); Davis, *supra* note 1, at 315-16.

7. While families with incomes of \$5,000 and more constitute only ten per cent of the total American families, they provide thirty per cent of the expenditures for medical facilities. The poorer fifteen per cent account for only seven per cent of the national health bill. FALK, KLEM, AND SINAI, *THE INCIDENCE OF ILLNESS AND THE RECEIPT AND COSTS OF MEDICAL CARE AMONG REPRESENTATIVE FAMILY GROUPS* (1933) 246.

8. See Winslow, *The Health Front in a People's War* (1942) 31 *SURVEY GRAPHIC* 101, 102.

9. For the objectives of group practice, see generally CABOT, *op. cit. supra* note 4, c. vi; CLARK AND CLARK, *ORGANIZATION AND ADMINISTRATION OF GROUP MEDICAL PRACTICE* (1941) 8-19; COMMITTEE FOR RESEARCH ON MEDICAL ECONOMICS, *GROUP MEDICAL PRACTICE* (1941); Roberts, *Group vs. Solo Practice* (1943) 20 *MEDICAL ECONOMICS* 103.

10. "The central problem in the costs of medical care for all but the very poor is not the actual size of the bill but its uncertain and variable size." FALK, KLEM, AND SINAI, *op. cit. supra* note 7, at 247. See FALK, *SECURITY AGAINST SICKNESS* (1937) c. II.

payment of the service. Since illness strikes at random, its cost falls unevenly on the individual family in a given year¹¹ and is, unlike other basic family expenses, unpredictable and difficult to budget in advance. Yet, for large groups of people and over periods of time, the total cost of medical care can be anticipated by application of well known actuarial principles. Thus, by contribution to a common medical insurance fund, the financial burden of illness becomes correspondingly more bearable to a larger portion of the population than if paid for individually in the traditional fee for service manner.

Experimentation with group health plans utilizing the principle of group prepayment, in conjunction with either individual or group practice, has taken diverse forms, varying with the sponsorship of the arrangement.¹² Commercial insurance companies offer health policies, but these are, however, of negligible importance.¹³ Most group health plans are non-profit, and have been sponsored by industrial corporations, consumer cooperatives, groups of physicians, or medical societies. Industrial plans are designed to cover the employees of a business concern and their families and have been financed either by employers or employees or by both.¹⁴ In a common arrangement, the company provides the initial capital outlay and employees contribute the operating costs. Organized groups of consumers, such as fraternal orders, cooperatives, and trade unions, have also initiated plans, generally characterized by a varying measure of lay control of administration.¹⁵ These prepayment schemes may provide physicians' services through their own organization of physicians practicing as a group, or by contracting with an independent service organization, or through physicians practicing individually.¹⁶ Plans sponsored by physicians working together in so-called "group clinics" may, also, offer services on a prepayment basis to individuals or organized groups of consumers.¹⁷ Finally, prepayment schemes initiated by local medical societies, for

11. The Committee on the Cost of Medical Care found that "less than 4 per cent of the families collectively incurred as much as 80 per cent incurred collectively." See COMMITTEE ON THE COSTS OF MEDICAL CARE, *op. cit. supra* note 3, at 17-18.

12. For convenient classification of these plans, see GOLDMANN, *PREPAYMENT PLANS FOR MEDICAL CARE* (1941); DAVIS, *AMERICA ORGANIZES MEDICINE* (1941); WILLIAMS, *THE PURCHASE OF MEDICAL CARE THROUGH FIXED PERIODIC PREPAYMENT* (1932).

13. See generally Rogers, *The Private Insurance Companies and a Suggested Medical Service Plan* (1942) 38 W. VA. MED. J. 201; MASLOW, *THE INTELLIGENT CONSUMER'S GUIDE TO HOSPITAL AND MEDICAL PLANS* (1942) 24-25.

14. See, as examples, Endicott Johnson Company Medical Service; Stanacola Employees Medical and Hospital Association, Inc. See Goldmann, *Medical Care in Industry* (1941) 1 MEDICAL CARE 301, (1942) 2 MEDICAL CARE 3; CARPENTER, *MEDICAL CARE FOR 15,000 EMPLOYEES AND THEIR FAMILIES* (1930); DAVIS, *COMPANY SICKNESS BENEFIT PLANS FOR WAGE EARNERS* (1936).

15. See, as examples, The Farmers' Union Cooperative Hospital Association of Oklahoma; Group Health Association of Washington, D. C.

16. See Clarke and Peterson, *How Subscribers to Group Health Plans Cooperate with Physicians* (1941) 1 MEDICAL CARE 222.

17. See, as examples, ROSS-LOOS Medical Group of Los Angeles; Milwaukee Medical Center of Wisconsin. See ROREM, *PRIVATE GROUP CLINICS* (1931).

consumers below the "comfort level," provide for individual practice, and are open to the participation of all the physicians of the community, from whom subscribers may choose freely.¹⁸

Besides these variations in organization of services and sponsorship, group health plans also differ fundamentally in respect to the scope of benefits offered. Cash indemnity plans, reimbursing the subscriber for specified medical expenses as opposed to actual rendition of services, have been offered by some industrial corporations and commercial insurance companies; but administrative handicaps have thoroughly discredited such plans, despite their endorsement by the American Medical Association. Today, the consensus of sound medico-economic opinion favors service plans,¹⁹ of which there are various types. Hospital service plans, limited to certain forms of hospital care and to specified periods of time, have grown rapidly and at present have over nine million subscribers, more members than all other types of plans combined.²⁰ Recent medical society endorsement has fostered plans limiting coverage to physician's care;²¹ while combination service plans offering all basic medical services with more or less complete coverage, including domiciliary and ambulatory care, hospitalization, laboratory and roentgenological services, have only recently developed.²²

Out of this varied experience with new forms of distributing and financing medical care, certain principles have already emerged as basic to the successful servicing of a large portion of the population at a price within its means. Early diagnosis and treatment of disease, a primary precept of modern medicine, is best attained through arrangements offering complete coverage of the fundamental services.²³ And if the individual must obtain the various services through separate plans, continuity and consistency of treatment become less likely. In addition, the cost of such complete coverage must be kept sufficiently low to permit participation of as large a number of potential consumers as possible. To secure a sufficient spread of risks, membership must be large and representative of an adequate cross-section of the population.²⁴ Moreover, as membership increases, unit administrative costs decrease.²⁵ Finally, sub-

18. See, as examples, California Physicians Service; Western New York Medical Plan. See generally DAVIS, *op. cit. supra* note 12; McCann, *Organization of a Medical Society Prepayment Plan* (1942) 2 MEDICAL CARE 134.

19. See Brown, *American Experimentation in Meeting Medical Needs by Voluntary Action* (1939) 6 LAW & CONTEMP. PROB. 507, 515; Winslow, *Medical Care for the Nation* (1939) 28 YALE REVIEW 501, 516-17; (1941) 1 MEDICAL CARE 120-23.

20. See generally ROREM, *NON-PROFIT HOSPITAL SERVICE PLANS* (1940).

21. See *Health Insurance* (1942) 2 MEDICAL CARE 68.

22. See DAVIS, *op. cit. supra* note 12.

23. See Goldmann, *supra* note 14, at 311 *et seq.*

24. See Goldmann, *A Hospital Service Plan in a Small Community* (1942) 16 HOSPITALS 56.

25. See Sander and Klem, *Services and Costs in a Prepayment Medical Care Plan* (1942) 2 MEDICAL CARE 215; GOLDMANN, *op. cit. supra* note 12, at 39-41.

stantial economies may be realized through organization of services, since expensive equipment and personnel requisite to modern practice can be used jointly more fully.

Present experience with group health plans is still too limited, however, to settle many other important aspects of prepayment and group practice. It is still controversial, for example, whether physicians should be remunerated by the unit system or on a capitation or salary basis.²⁶ Similarly, the scope of government, lay, and professional control, as well as many other aspects of internal administration of group practice, remain unsettled.²⁷ Pressing, too, is the problem how best to integrate group health plans with other public and private schemes for distributing care under a national health program.²⁸ Since it is conceded that voluntary health insurance can at best cover no more than one-fourth of the population,²⁹ it will have to be supplemented with state care of the indigent and compulsory insurance for those occupational and economic groups which will not subscribe to health plans voluntarily.³⁰ More data must, therefore, be assembled through further experimentation before any conclusive determination can be reached as to the type of arrangement most suitable to the diverse economic groups in the population.

Experimentation with group health plans, however, has been seriously hampered by the application of stringent controls. Supervision designed to assure high quality of service and financial solvency is undoubtedly desirable, in view of the danger of commercialization present in these plans notwithstanding their initiation under non-profit auspices. But existing controls seem to be based on a philosophy of restrictionism stemming from opposition to the radical change in traditional medico-economic institutions which group health entails. While group prepayment itself has been tacitly accepted, its conjunction with group practice is still denounced by organized medicine, apparently because the reduction in the cost of service which such a plan realizes seriously challenges the competitive position of traditional individual practice on a fee for service basis. Present regulatory safeguards must, therefore, be carefully scrutinized in the light of limited experience with group health plans and need for further experimentation.

JUDICIAL CONTROLS: THE CORPORATE PRACTICE OF MEDICINE

Use of the corporate form of organization, which has been widely adopted in group health schemes because of its distinct advantages of limited liability,

26. See CSONTOS, DISCUSSION OF THE VARIOUS PROVISIONS TO BE CONSIDERED IN DRAFTING A BILL FOR HEALTH INSURANCE (1941) 30-35.

27. See Winslow, *supra* note 19, at 519.

28. See generally DAVIS, *op. cit. supra* note 12; Winslow, *supra* note 19.

29. See Goldmann, *Voluntary Health Insurance* (1941) 77 SURVEY MID-MONTHLY 80, 82.

30. For an excellent discussion of compulsory health insurance, see SIMPSON, COMPULSORY HEALTH INSURANCE IN THE UNITED STATES (1943).

continuity of existence, and transferability of interests,³¹ has furnished a ground for judicial intervention. Corporations contracting to furnish medical services have been charged with violation of licensure acts, which require that a "person" have a license to practice medicine.³² Even though the services be rendered by a duly licensed physician, courts have said that since the practitioner is the corporation's agent, the corporate body is, under the doctrine of *respondet superior*, practicing medicine.³³ In view of the inherent inability of a corporate entity to comply with the educational and character requirements necessary to secure a license,³⁴ such a rationale would prohibit use of the corporate device.

Various arguments may be marshalled, however, for a legal attack upon the notion that corporate participation through duly licensed physicians is practice of medicine in violation of the licensure acts. Without challenging the corporate entity fiction,³⁵ it might be argued that the physician is not an "agent" of the corporation but an independent contractor.³⁶ There is author-

31. The advantages of a corporate form of organization to a group health plan are discussed in Peart and Hassard, *The Organization of California Physicians' Service* (1939) 6 LAW & CONTEMP. PROB. 565, 567.

32. State medical practice acts are compiled in AMERICAN MEDICAL ASSOCIATION, LAWS AND BOARD RULINGS REGULATING THE PRACTICE OF MEDICINE IN THE UNITED STATES (1928). See generally Comment (1937) 6 FORDHAM L. REV. 438.

Regulation of medicine through medical practice acts is a proper exercise of the police power. *Lambert v. Yellowley*, 272 U. S. 581, 596 (1926) ("... there is no right to practice medicine which is not subordinate to the police power of the States."); *Dent v. West Virginia*, 129 U. S. 114 (1889).

33. *Painless Parker v. Dental Examiners*, 216 Cal. 285, 14 P. (2d) 67 (1932); *State Dental Examiners v. Savelle*, 90 Colo. 177, 8 P. (2d) 693 (1932); *People ex rel. Kerner v. United Medical Service*, 362 Ill. 442, 200 N. E. 157 (1936); *State v. Bailey Dental Co.*, 211 Iowa 781, 234 N. W. 260 (1931); cf. *People ex rel. State Medical Examiners v. Pacific Health Corp.*, 12 Cal. (2d) 156, 82 P. (2d) 429, 119 A. L. R. 1284, 1290 (1938), *cert. denied*, 306 U. S. 633 (1939); *Benjamin Franklin Life Assurance Co. v. Mitchell*, 14 Cal. App. (2d) 654, 58 P. (2d) 984 (1936); *Bartron v. Codrington County*, 2 N. W. (2d) 337 (S. D. 1942); *Pacific Employers Insurance Co. v. Carpenter*, 10 Cal. App. (2d) 592, 52 P. (2d) 992 (1935); see 1 FLETCHER, PRIVATE CORPORATIONS (1931) § 97. *Contra*: *Group Health Association v. Moor*, 24 F. Supp. 445 (D. D. C. 1938); *State ex inf. Sager v. Lewin*, 128 Mo. App. 149, 106 S. W. 581 (1907); *State Electro-Medical Institute v. Platner*, 74 Neb. 23, 103 N. W. 1079 (1905); *State Electro-Medical Institute v. State*, 74 Neb. 40, 103 N. W. 1078 (1905); see generally (1938) 48 YALE L. J. 346.

34. "A corporation, as such, has neither education nor skill nor ethics. These are *sine qua non* to a learned profession." *Iowa v. Bailey Dental Co.*, 211 Iowa 781, 785, 234 N. W. 260, 262 (1931).

35. Compare Laski, *The Personality of Associations* (1916) 29 HARV. L. REV. 404 with COHEN, REASON AND NATURE (1931) 386-400.

36. In *Group Health Association v. Moor*, 24 F. Supp. 445 (D. D. C. 1938), the court, in exempting a group health plan from the charge of violation of the licensure act, said: "It is true that a corporation can act only through its agents and employees, but the physicians with whom the plaintiff makes contracts are rather in the position of inde-

ity, also, for deeming the corporation itself an agent, bringing together physician and patient.³⁷ But even if the physician is viewed as the agent and the corporation as the principal, established agency principles would attribute to the corporate entity not the *acts* but the *consequences* arising from the physician's conduct if wrongful.³⁸ Still another attack may be grounded on the original intent of licensure acts. Since the purpose of licensure was to assure professional competence and natural persons must therefore have been contemplated, the only issue should be whether physicians actually rendering the service are duly licensed.³⁹ Thus the administrative task of furnishing services should be distinguished from the practice of medicine—diagnosis of the disease and administering the proper therapy⁴⁰—to emphasize that licensure acts regulate only the latter.⁴¹

pendent contractors, and the plaintiff does not in any way undertake to control the manner in which they attend or prescribe for their patients." *Id.* at 446. *Cf.* *Guilliams v. Hollywood Hospital*, 18 Cal. (2d) 97, 114 P. (2d) 1 (1941); *South Florida R. R. v. Price*, 32 Fla. 46, 13 So. 638 (1893); *Fowler v. Norways Sanitarium*, 42 N. E. (2d) 415 (Ind. 1942); *Pearl v. West End St. Ry.*, 176 Mass. 177, 57 N. E. 339 (1900); see *Comment* (1938) 48 *YALE L. J.* 81; *RESTATEMENT, AGENCY* (1933) § 223(a); *Iterman v. Baker*, 214 Ind. 308, 318-19, 15 N. E. (2d) 365, 370 (1938). But *cf.* *McMurdo v. Getter*, 298 Mass. 363, 10 N. E. (2d) 139 (1937).

37. Compare *Jordan v. Group Health Association*, 107 F. (2d) 239 (App. D. C. 1939). See the dissenting opinion in *People ex rel. State Board of Medical Examiners v. Pacific Health Corporation*, 12 Cal. (2d) 156, 163, 82 P. (2d) 429, 432, 119 A. L. R. 1284, 1290 (1939), *cert. denied*, 306 U. S. 633 (1939) ["Here the corporation is acting as an agency for bringing the doctor and patient together The situation is legally no different from that where A (who may be a layman or a corporation) secures medical services for B from C, a duly licensed physician, C agreeing to look solely to A for his fee. Could it be successfully contended that A is practicing medicine? I think not."].

38. See *Laufer, Ethical and Legal Restrictions on Contract and Corporate Practice of Medicine* (1939) 6 *LAW & CONTEMP. PROB.* 516, 525-26.

39. Compare *The Pharmaceutical Society v. The London and Provincial Supply Association*, 5 App. Cas. 857 (1880); see *Langdon, J.*, dissenting, in *Painless Parker v. Board of Dental Examiners*, 216 Cal. 285, 309, 14 P. (2d) 67, 77 (1932) (" . . . when the regulatory statute refers to the licensing of 'persons' it intends natural and not artificial persons."). See also *State Electro-Medical Institute v. Platner*, 74 Neb. 23, 25, 103 N. W. 1079, 1080 (1905) (" . . . it is the one who actually performs the surgical operation or administers the remedy that must be qualified and licensed under the statute").

40. See *Underwood v. Scott*, 43 Kan. 714, 717, 23 Pac. 942, 943 (1890); *State Electro-Medical Institute v. State*, 74 Neb. 40, 103 N. W. 1078 (1905); *State v. Karsunky*, 197 Wash. 87, 92, 84 P. (2d) 390, 393 (1938).

41. *State ex inf. Sayer v. Lewin*, 128 Mo. App. 149, 106 S. W. 581 (1907). In *State Electro-Medical Institute v. State*, 74 Neb. 40, 103 N. W. 1078 (1905), the distinction was relied on to exempt a group clinic from charge of violation of licensure acts. The court said: "The intention of the law is that one who undertakes to judge the nature of the disease, or to determine the proper remedy therefor, or to apply the remedy, must have certain personal qualifications, and if he does these things without having complied with the law he is subject to its penalties. Making contracts is not practicing medicine No professional qualifications are requisite for doing these things." *Id.* at 43, 103 N. W. at 1079. See *State v. Brown*, 37 Wash. 97, 79 Pac. 635 (1905); *cf.* *Liggett v. Baldrige*,

Yet while courts generally talk in terms of licensure, a factual analysis of the cases would seem to indicate that public policy considerations underlie the corporate practice concept. These considerations, occasionally voiced by way of dicta, apparently stem from the danger that the practitioner's employment by a profit motivated corporation might weigh his loyalty too heavily in favor of the employer and thus disrupt the intimate physician-patient relationship thought necessary to proper medical treatment.⁴² It is feared, also, that commercialization of the profession would lead to exploitation of physician or patient and impairment of medical standards.⁴³ Though generally unexpressed, these fears would seem to account for the result in many of the cases. Thus, other professions in which the possibilities for commercial exploitation of client or practitioner are not as great as those offered by medicine or law have been judicially excepted from the rule against corporate practice.⁴⁴

278 U. S. 105 (1928); *Messner v. Board of Dental Examiners*, 87 Cal. App. 199, 262 Pac. 58 (1927); *Pilger v. City of Paris Co.*, 86 Cal. App. 277, 261 Pac. 328 (1927); *Fowler v. Norway Sanitarium*, 42 N. E. (2d) 415 (Ind. 1942); see also *Johnson v. Stumbo*, 277 Ky. 301, 318-19, 126 S. W. (2d) 165, 175 (1939).

As early as 1756, Lord Mansfield held that a licensing statute regulating the skilled trades was not applicable to the unlicensed partner of a licensed tradesman since the former handled only the business side of the firm, declaring: "Now here the personal skill of the defendant makes no real difference in the case, for the person who is skilful acts everything . . ." *Raynard v. Chase*, 1 Burr. 37, 97 Eng. Rep. 155, 156 (K. B. 1756).

In exempting architecture from the "corporate practice" prohibition, courts have relied on this distinction between the administrative and professional tasks. See *People v. Allied Architects Association*, 201 Cal. 428, 257 Pac. 511 (1927); *Binford v. Boyd*, 178 Cal. 458, 174 Pac. 56 (1918); *People ex rel. State Board of Examiners of Architects v. Rodgers Co.*, 277 Ill. 151, 115 N. E. 146 (1917).

42. See *In re Co-operative Law Co.*, 198 N. Y. 479, 92 N. E. 15 (1910); *Wormser, Corporations and the Practice of Law* (1936) 5 FORDHAM L. REV. 207, 211; *People ex rel. State Board of Medical Examiners v. Pacific Health Corporation*, *cert. denied*, 305 U. S. 633 (1939).

In *Dr. Allison, Dentist v. Dr. Allison*, 360 Ill. 638, 196 N. E. 799, 800 (1935) the court emphasized that a corporation could not practice medicine because "its employees must owe their first allegiance to the corporate employer and cannot give the patient anything better than a secondary or divided loyalty."

43. See, *e.g.*, *Bartron County v. Codington*, 2 N. W. 337, 346 (S. D. 1942) ("The object of such a company would be to produce an earning on its fixed capital. Its trade commodity would be the professional services of its employees. Constant pressure would be exerted by the investor to promote such a volume of sales of that commodity as would produce an ever increasing return on its investment. To promote such sales it is to be presumed that the layman would apply the methods and practices in which he had been schooled in the market place. The end result seems inevitable . . . *viz.*, undue emphasis on mere money making, and commercial exploitation of professional services.").

44. *Liggett Co. v. Baldrige*, 278 U. S. 105 (1928) (pharmacy); *Binford v. Boyd*, 178 Cal. 458, 174 Pac. 56 (1918) (architecture); *People ex rel. State Board of Examiners of Architects v. Rodgers Co.*, 277 Ill. 151, 115 N. E. 146 (1917) (architecture); *cf.* *Raynard v. Chase*, 1 Burr. 3, 97 Eng. Rep. 155 (K. B. 1756). There is a definite split of authority concerning the "practice" of optometry by proprietary corporations.

It is significant, too, that those corporations held practicing medicine in violation of the licensure acts were characterized by high pressure solicitation, lay control, or a streak of quackery. For example, charlatanry was in fact present in organizations advertising secret cancer cures⁴⁵ or "painless" treatments.⁴⁶ Similarly, policy objections would seem implicit in decisions against lay controlled insurance companies selling health policies through highly competitive business methods.⁴⁷ On the other hand, fraternal organizations, charitable institutions, and industrial corporations have long furnished medical services without judicial interference though using the corporate form.⁴⁸ In *Group Health Association v. Moor*,⁴⁹ a prepayment plan on a group practice basis was deemed not to have violated the licensure acts, although there was no discussion of public policy objections to corporate practice. More important, perhaps, is the recent case of *Bartron v. Codrington County*,⁵⁰ involving a business corporation, run for profit by a group of physicians, which had contracted with the county to furnish medical services to indigents. In invalidating the contract, the court deemed the notion that a corporation may violate the licensure acts nonsensical, resting its decision instead on the theory that the furnishing of services by a corporation operated for gain tends to commercialize and debase the profession and is, therefore, against public policy. While the result might be attacked, the approach, in focusing attention on the underlying policy considerations concealed by other courts behind categorical dec-

For cases holding that such a corporation may not practice, see *Funk Jewelry Co. v. State*, 46 Ariz. 348, 50 P. (2d) 945 (1935); *McMurdo v. Getler*, 298 Mass. 363, 10 N. E. (2d) 139 (1937); *Stern v. Flynn*, 154 Misc. 609, 278 N. Y. S. 598 (1935); *Neill v. Gimbel Brothers*, 330 Pa. 213, 199 Atl. 178 (1938); see also Comment (1937) 11 TEMPLE L. Q. 232. Proprietary corporations were allowed to practice optometry in *Dvorine v. Castelberg Jewelry Corp.*, 170 Md. 661, 185 Atl. 562 (1936); *State ex inf. McKittrick v. Gate City Optical Co.*, 339 Mo. 427, 97 S. W. (2d) 89 (1936); *Jaecle v. Bamberger & Co.*, 119 N. J. Eq. 126, 181 Atl. 181 (1935); see also (1936) 85 U. OF PA. L. REV. 118.

45. See *Iowa v. Bailey Dental Co.*, 211 Iowa 781, 234 N. W. 260 (1931).

46. See *Painless Parker v. Board of Dental Examiners*, 216 Cal. 285, 14 P. (2d) 67 (1932); *People v. Painless Parker, Dentist*, 85 Colo. 304, 275 P. 928 (1929), *cert. denied*, 280 U. S. 566 (1929). But *cf. State ex inf. Sager v. Lewin*, 128 Mo. App. 149, 106 S. W. 581 (1907).

47. See *People ex rel. State Board of Medical Examiners v. Pacific Health Corporation*, 12 Cal. (2d) 156, 82 P. (2d) 429, 119 A. L. R. 1284, 1290 (1938), *cert. denied*, 306 U. S. 633 (1939); *Benjamin Franklin Life Assurance Co. v. Mitchell*, 14 Cal. App. (2d) 654, 58 P. (2d) 984 (1936); *Pacific Employers Insurance Co. v. Carpenter*, 10 Cal. App. (2d) 592, 52 P. (2d) 992 (1935).

48. *Butterworth v. Boyd*, 12 Cal. (2d) 140, 82 P. (2d) 434 (1938). See *Benjamin Franklin Life Assurance Co. v. Mitchell*, 14 Cal. App. (2d) 654, 658-59, 58 P. (2d) 984, 986 (1936); *State ex inf. Sager v. Lewin*, 128 Mo. App. 149, 155, 106 S. W. 581, 583 (1907) ("No one has ever charged that these corporations were practicing medicine . . .").

49. 107 F. (2d) 239 (App. D. C. 1939).

50. 2 N. W. (2d) 337 (S. D. 1942).

larations that the corporation is violating the licensure acts, would seem to be sound.

If the public policy basis of judicial intervention were recognized, nicer discrimination between various types of arrangements, instead of outright proscription of all corporate entities, would be possible. Employment of the physician by a corporation would seem to divide his loyalty and thus impair the confidential physician-patient relationship only if it introduces a third interest.⁵¹ A distinction should, therefore, be drawn between employment by a lay business corporation and a non-profit organization. In the case of charitable institutions, industrial plans, and consumer cooperatives, the interests of corporate employer and patient are generally identical; while in health plans organized by groups of physicians the doctors may be identified with the corporate entity. On the other hand, policy objections could validly be levelled against lay controlled business corporations, since there the employer's personal pecuniary interest may seriously impair the physician's loyalty to the patient and thus affect the quality of the service. Similarly, commercial exploitation and impairment of professional standards appear much more likely when the arrangement is initiated by commercial insurance companies than under non-profit auspices. Admittedly, a profit motive criterion might often prove too superficial and closer judicial scrutiny of the set-up as a whole become desirable. But, since judicial supervision lacks necessary expertness and continuity of attention, courts should proscribe an arrangement, if at all, only when it is clearly conducive to commercialization and impairment of medical standards. Careful surveillance of group health, though undoubtedly needed, should emanate from more skilled public and professional bodies.

LEGISLATIVE CONTROLS: THE NEW CONCEPT OF HEALTH INSURANCE

If judicial control of group health plans were reduced to a minimum, expert government supervision of financial and medical standards would be required. In some states, regulation has been achieved by classification of prepayment schemes as insurance projects subject to state insurance laws.⁵² These laws, designed to protect the public against possible fraud and deception by financially irresponsible insurers,⁵³ require would-be insurers to make a large initial capital investment and to maintain high reserves as well as elaborate business records.⁵⁴ Since full compliance with these stringent requirements would seriously hamper the formation and operation of group health plans,⁵⁵ it is

51. See Laufer, *supra* note 38, at 524-25.

52. See, *e.g.*, OPS. ATT'Y GEN. MASS. 545 (1898); OPS. ATT'Y GEN. N. Y. 348 (1932); OPS. ATT'Y GEN. N. Y. 217 (1895). But see 2 OPS. ATT'Y GEN. MASS. 226 (1900).

53. See VANCE, INSURANCE (1930) 28-34; PATTERSON, CASES AND MATERIALS ON INSURANCE (1932) 47.

54. See, *e.g.*, N. Y. INS. LAW § 71(a).

55. See Peart and Hassard, *supra* note 31, at 569-70.

important to consider the rationale by which such plans might be brought under the insurance laws.

In holding a transaction amenable to the state regulatory laws, courts have pointed to the presence of the basic elements of insurance.⁵⁶ In general, these elements are said to be the existence of a risk of economic loss to the promisee,⁵⁷ its assumption by the promisor,⁵⁸ and distribution of such risk over a group of people similarly subject to it.⁵⁹ Such a definitional approach was followed by the Court of Appeals for the District of Columbia in *Jordan v. Group Health Association*.⁶⁰ In exempting a non-profit prepayment plan on a group practice basis from the insurance laws, the court said that the organization was not engaged in the business of insurance because it had not assumed any risk. Emphasizing the technical legal character of the arrangement, Judge Rutledge declared that the health association involved was not contractually bound "to provide the service, or see that it is supplied . . . but only to use its best efforts to secure similar service"; and functionally, he then added, the organization operated merely ". . . to reduce the cost rather than the risk of medical care." Because of the decision's probable persuasive weight in other jurisdictions, care should be taken by organizers of health plans in drafting contracts with subscribers to provide that the organization is not technically bound to supply the services and promises merely to use its best efforts to secure them. But, despite the desirable result reached by the decision, it might be criticized for its emphasis on the technical nature of the obligation of Group Health Association to its members and for its failure to recognize the underlying risk-distribution function of prepayment—to insure the potential patient against the unpredictable occurrence of sickness.⁶¹

A more functional approach than a definitional analysis would be to recognize group health prepayment as insurance, but of a type not regulated by state insurance laws.⁶² That these statutes were not aimed at regulation of all insurance contracts but only of those which require careful protection of the insured is inferrable from the very stringency of the controls. Recognition that only this type of insurance falls within the statutes is dictated by the

56. See Notes (1939) 119 A. L. R. 1241, (1936) 100 A. L. R. 1449, (1929) 63 A. L. R. 711. See generally Levy and Mermin, *Cooperative Medicine and the Law* (1938) 1 NAT. LAWYERS GUILD Q. 194, 206-07.

57. *Stern v. Rosenthal*, 71 Misc. 422, 128 N. Y. Supp. 711 (Sup. Ct. 1911).

58. See *Jordan v. Group Health Association*, 107 F. (2d) 239 (App. D. C. 1939); *Colaizzi v. Penn. R. R.*, 208 N. Y. 275, 101 N. E. 859 (1913); *State ex rel. Fishback v. Universal Service Agency*, 87 Wash. 413, 151 P. 768 (1915).

59. See *Home Title Insurance Co. v. United States*, 50 F. (2d) 107, 110 (C. C. A. 2d, 1931), *aff'd*, 285 U. S. 191 (1932); see also VANCE, *op. cit. supra* note 53, at 2; (1936) 36 COL. L. REV. 456, 458, n. 10.

60. 107 F. (2d) 239 (App. D. C. 1939).

61. See pages 163-64 *supra*.

62. See (1939) 52 HARV. L. REV. 809, 815; (1936) 36 COL. L. REV. 456, 465.

increasing use of risk-distributing devices, for business promotion and other purposes, needing much milder regulation.⁶³ Moreover, while ostensibly courts have determined the applicability of regulatory laws to a transaction simply on a definitional basis, there is legal authority for a less superficial criterion related to the speculative nature of the proposed scheme. Thus, burial contracts have been held within the statutes though clearly lacking essential insurance elements,⁶⁴ probably because they create a fund in the hands of a profit motivated company from which disbursements must be made to the promisees; while benevolent fraternal orders⁶⁵ and associations of railroad employees⁶⁶ offering life and fire insurance policies have been judicially exempted, since in those situations there is less need for the statutory safeguards to protect the insured against the insurer's inability to pay. By analogy to the latter, courts should rule that a non-profit health prepayment plan falls outside the scope of state laws, for not only are these plans non-profit and membership controlled, with consequent identification of insured and insurer, but the relatively regular and continuous nature of service and the emphasis on preventive care reduce the element of contingency.⁶⁷

While state insurance laws are not suitable to group health plans, there is, nevertheless, need for specially designed statutory supervision of health schemes. As plans grow larger, control may pass to a self-perpetuating management and supervision of financial and medical standards by the membership become increasingly difficult.⁶⁸ More significantly, the side sponsoring the plan, whether consumer or physician, may acquire such overwhelming bargaining power as to necessitate state protection of the weaker non-organized party. The need becomes particularly acute in jurisdictions where there is no possibility of regulation through the corporation laws because judicial interpretation of the licensure acts prevents incorporation of group health plans.⁶⁹

This need for statutory controls specially adapted to group health plans has been recognized, if not met, by various enabling acts. The most common type authorizes incorporation of a non-profit association to contract with potential patients for the rendition of hospital services by a participating hospital

63. See Note (1938) 48 YALE L. J. 117.

64. State *ex rel.* Landis v. DeWitt C. Jones Co., 108 Fla. 613, 147 So. 230 (1933); South Georgia Funeral Homes v. Harrison, 182 Ga. 60, 184 S. E. 875 (1936); Benevolent Burial Ass'n v. Harrison, 181 Ga. 230, 181 S. E. 829 (1935); Bedell v. Oliver H. Blair Co., 104 Pa. Super. Ct. 146, 158 Atl. 651 (1931).

65. Fisher v. American Legion of Honor, 168 Pa. 279, 31 Atl. 1089 (1895); Northwestern Masonic Aid Ass'n of Chicago v. Jones, 154 Pa. 99, 26 Atl. 253 (1893).

66. Colaizzi v. Pennsylvania R. R., 208 N. Y. 275, 101 N. E. 859 (1913); State *ex rel.* Sheets v. Pittsburgh, C. C. & St. L. R. R., 68 Ohio St. 9, 67 N. E. 93 (1904).

67. See Levy and Mermin, *supra* note 56, 209-10. But *cf.* (1937) 23 CORN. L. Q. 183, 191.

68. See Levy and Mermin, *supra* note 56, at 214-15.

69. See page 167 *supra*.

or group of hospitals.⁷⁰ These acts generally exempt the organization from the regulations of insurance laws, distinguishing a non-profit health arrangement from a commercial insurance scheme. Immediate supervision by a state officer, usually the commissioner of insurance, is, nevertheless, provided. Such officer, besides approving the charter of incorporation and the rates to be charged subscribers and participating hospitals, checks the finances of the organization from its reports and by personal inspection. In general, plans are exempted from taxes except those on property. It is, also, frequently required that the plan be opened for participation to all hospitals in the community, from which patients may choose freely, and that the type of service be limited to services that are ordinarily rendered by hospitals, thus excluding general physician and surgical care.

This exclusion of medical and surgical care from hospitalization plans has induced the enactment of separate acts enabling medical service arrangements, generally patterned after existing medical society plans.⁷¹ In general, not only are hospital services excluded, but participation in the plan must be open to all duly licensed physicians, who are to distribute services on an individual practice basis. Medical society control is generally assured by requiring its approval of the plan as well as of the governing body appointed.

70. See ALA. CODE (1940) tit. 28, art. 3; CAL. INS. CODE (Deering, 1937) art. 4, as amended by CAL. INS. CODE (Deering, Supp. 1941) §§ 11502-03; CONN. GEN. STAT. (Supp. 1939) c. 192c; GA. CODE ANN. (Supp. 1941) c. 99-100; ILL. REV. STAT. (1943) c. 32, §§ 554-62; IOWA CODE (Reichmann, 1939) c. 403.1; KAN. GEN. STAT. ANN. (Corrick, Supp. 1941) c. 40, art. 18; KY. REV. STAT. (1942) §§ 303.010-303.080; LA. GEN. STAT. (Dart., Supp. 1942) §§ 4170.38-4170.54; MD. ANN. CODE (Flack, 1939) art. 48A, §§ 235-43; MASS. ANN. LAWS (Supp. 1942) c. 176A, c. 176B, c. 176C; MICH. STAT. ANN. (Supp. 1943) §§ 24.621-24.638; MINN. STAT. (Mason, Supp. 1941) §§ 7900a-7900h; MISS. CODE ANN. (Supp. 1938) c. 122D; NEB. COMP. STAT. (Kyle, Supp. 1941) art. 24, §§ 2001-13; N. H. REV. LAWS (1942) c. 334; N. J. STAT. ANN. (1930) tit. 17, §§ 48.1-48.18; N. M. STAT. ANN. (1941) §§ 60-1001-60-1011; N. C. LAWS (1943) c. 537; N. D. LAWS (1943) c. 103; OHIO CODE ANN. (Page, Supp. 1942) §§ 669-669-13; §§ 669-14-669-39 (Group Medical Care Associations) as amended by OHIO CODE ANN. (Supp. 1943) §§ 669-11, 669-32; ORE. COMP. LAWS ANN. (1940) §§ 101-32; PA. STAT. ANN. (Purdon, 1936) tit. 15, §§ 2851-1301-2851-1309; R. I. GEN. LAWS ANN. (1938) c. 719; S. C. CODE (1942) §§ 8113-1-8113-17; TEX. ANN. REV. CIV. STAT. (Vernon, Supp. 1943) art. 4590a; Vt. LAWS (1939) 187-89, amended by Vt. LAWS (1941) 152-53; VA. CODE ANN. (Mitchie & Sublett, 1942) § 3848(67); W. VA. CODE (1943) §§ 3242(54)-3242(60); WIS. STAT. (1941) § 180.32. See generally Rorem, *Enabling Legislation for Non-Profit Hospital Service Plans* (1939) 6 LAW & CONTEMP. PROB. 528.

71. See MASS. ANN. LAWS (Supp. 1942) c. 176C; MICH. STAT. ANN. (Supp. 1943) §§ 24.591-24.607; N. J. STAT. ANN. (Supp. 1943) tit. 17, §§ 48A(1)-48A(25) (Medical Service Corporations); N. Y. INS. LAW §§ 250-59 (Non-Profit Medical Indemnity, or Hospital Service Corporations), as amended by MCKINNEY'S CONS. LAWS (Supp. 1943) §§ 251, 256, 260; N. C. CODE ANN. (Supp. 1941) c. 102A, as amended by Session Laws (1943) c. 537; OHIO CODE ANN. (Page, Supp. 1942) §§ 669.14-669.39; OHIO CODE ANN. (Supp. 1943) §§ 669.11, 669.32; PA. STAT. ANN. (Purdon, 1936) tit. 15, §§ 2851-1501-2851-1520; VA. CODE ANN. (Mitchie & Sublett, 1942) § 3848(67).

Existing enabling acts appear to be at best makeshift legislative responses to the pressing need for statutory authorization and supervision of group health plans. Legislation permitting the formation of a particular type of plan, sponsored by a pressure group strong enough to have its conception of health insurance legalized, offers little evidence that the over-all problem of medical prepayment and group practice has been considered. Since in most states legislatures have responded only to demands of medical societies,⁷² most acts sanction the limited type of plan advocated by organized medicine. As a result, no provisions have been made for enabling plans combining hospital, medical, and surgical care or for organization of physicians' services on a group practice basis. Such limitations, which are deemed unwise by the consensus of sound medico-economic opinion, seriously hamstring further experimentation with new forms of medical practice and prepayment. Moreover, emphasis is too often placed on regulation of fiscal technicalities by the insurance commissioner instead of on adequate attention to the need for expert supervision of medical standards by a public health agency. Legislation authorizing sound but broad experimentation with all types of health arrangements and adequate government regulation is still badly wanting.

PROFESSIONAL CONTROLS: THE AMERICAN MEDICAL ASSOCIATION'S CODE OF ETHICS

To date, the most pervasive control of group health plans has stemmed from the power of organized medicine to regulate the professional conduct of physicians. The relations of a practitioner with patients and fellow physicians are governed by the Code of Medical Ethics, which is interpreted and enforced by the American Medical Association through its hierarchy of medical courts pyramiding upwards from local and state medical societies to the American Medical Association's Judicial Council.⁷³ Justification for professional self-regulation is found in the need to protect the helpless patient, unable as he is to judge the quality of the service; for while government regulation may assure educational competence through licensure, it is felt that the highly fiduciary and vital nature of the service necessitates more personal controls.⁷⁴ Thus, organized medicine's disciplinary powers have in the past done yeoman work in combating quackery and enforcing a high standard of professional conduct and ethics.

The American Medical Association has powerful sanctions and disciplinary techniques to enforce its conception of medical ethics.⁷⁵ Expulsion from the

72. See Davis, *Health Insurance Plans Under Medical Societies* (1943) 3 MEDICAL CARE 217, 225.

73. See *The American Medical Association* (1938) 18 FORTUNE 89.

74. See generally Tausch, *Professional Ethics* in 12 ENCYC. SOC. SCIENCES 472 (1934).

75. See generally Garceau, *Organized Medicine Enforces its 'Party Line'* (1940) 4 PUBLIC OP. Q. 408; Record, *United States v. American Medical Association*, 28 F. Supp. 752 (D. D. C. 1939); RORTY, *AMERICAN MEDICINE MOBILIZES* (1939) 111-39.

medical society, the usual penalty for violation of the Code, spells probable ruin to the average physician, because of the society's power to bar the expelled physician access to local hospital facilities and to consultation with specialists. For today, as a result of far-reaching scientific advances, the general practitioner cannot possess all the specialized knowledge and technology requisite to proper diagnosis and treatment of complex cases. Local hospitals have generally been forced to yield to AMA requests that expelled physicians be denied the privilege of attending and treating patients there, since loss of AMA approval might render it difficult to procure interns and an adequate staff.⁷⁶ Similarly, local practitioners hesitate to consult with the expelled physician, lest the bludgeon of expulsion fall upon them too. And malpractice defense, an indispensable requisite of modern practice, becomes increasingly difficult and costly when fellow practitioners refuse to testify for the expelled doctor.⁷⁷ In view of the dire consequences thus attending expulsion, it is important for group health plans to consider the meaning of the AMA's Code of Ethics.

Physicians practicing for group health arrangements have most often been charged with violation of the section restricting so-called "contract practice." Contract practice originated during the last century, when fraternal lodges and industries hired salaried physicians to furnish medical services to members or employees.⁷⁸ Since the practitioner was underpaid and deplorable conditions and facilities rendered adequate service impossible, such practice was undoubtedly undesirable.⁷⁹ As a result, the 1912 Code of Ethics declared unethical "an agreement between a physician or a group of physicians, as principals or agents, and a corporation, organization . . . or individual, to furnish . . . medical services to a group or class of individuals on the basis of a fee schedule, or for a salary or a fixed rate per capita."⁸⁰ As amended in 1934, however, the Code does not proscribe contract practice per se but only if several conditions are present. These are: solicitation of patients; "underbidding to secure the contract"; inadequate compensation; ". . . interference with reasonable competition in a community"; ". . . free choice of physicians . . . prevented"; conditions of employment making it impossible to render adequate service; or a ". . . contract [which] because of any of its provisions is contrary to sound public policy."⁸¹ The loose character of these provisions

76. See generally *Indictment, United States v. American Medical Association*, 28 F. Supp. 752 (D. D. C. 1939).

77. See SHADID, *A DOCTOR FOR THE PEOPLE* (1939) 134.

78. See generally LELAND, *SOME PHASES OF CONTRACT PRACTICE* (1932); 2 BURR, *MEDICAL HISTORY OF MICHIGAN* (1930) 571-73.

79. See CABOT, *op. cit. supra* note 4, at 145. Some of the abuses of contract practice were also present in the administration of the Workmen's Compensation Laws. See DODD, *ADMINISTRATION OF WORKMEN'S COMPENSATION* (1936) 489-93.

80. See AMERICAN MEDICAL ASSOCIATION, *ECONOMICS AND THE ETHICS OF MEDICINE* (1935) 45-46.

81. AMERICAN MEDICAL ASSOCIATION, *PRINCIPLES OF MEDICAL ETHICS*, c. III, art. VI, § 2.

makes it necessary to turn to the cases applying them to ascertain their meaning.

In several unreported cases, physicians were expelled from medical society membership for participating in prepayment plans, organized by consumers or physicians, on a group practice basis.⁸² In those cases, the medical society found that the services rendered were of high quality, the physicians were properly remunerated, and the cost of care was reduced appreciably. The physicians were, nevertheless, expelled without further reason than a general statement that the arrangement was "contract practice contrary to sound public policy." Organized medicine has continuously failed to define this concept of "sound public policy" beyond the Judicial Council's pronouncement in one case that "anything which in effect is opposed to the ultimate good of the people at large is against sound public policy and therefore unethical."⁸³ But

82. In Stanacola Medical Association, an organization of employees of Standard Oil of Louisiana, was engaged in "procuring high grade medical services at a small cost" on a prepayment basis and through its own panel of physicians, which were paid from six to eight thousand dollars a year. The local medical society expelled these doctors from membership because their practice ". . . interferes with reasonable competition among physicians of the community" See *Irwin v. Lorio*, 169 La. 1090, 126 So. 669 (1930). Similarly, Trinity Hospital of Arkansas, which offered a prepayment plan on a group practice basis, was held to be engaged in "contract practice contrary to sound public policy." Most of the physicians were forced to leave the hospital, while the remaining had to resign from the local medical society. See *Record, United States v. American Medical Association*, 28 F. Supp. 752 (D. D. C. 1939) 247-50, 983-84. Again, Drs. Ross and Loos, owners of the famous group clinic in Los Angeles, were expelled by their local society for contracting with organized groups of consumers for rendition of services on a prepayment basis "contrary to sound public policy." Although the American Medical Association's Judicial Council reversed the state society on procedural grounds, without going into the merits, the Association has prevented the clinic from getting physicians from out of state. See (1936) 106 J. AMER. MED. ASSOC. 300. More widely publicized was the case of Dr. Shadid, organizer of the first consumers' cooperative group clinic for distribution of services on a prepayment basis. After a series of unsuccessful medical society attempts to revoke his license and to boycott the clinic, the society dissolved and emerged without Dr. Shadid and his associates as members. See generally SHADID, *op. cit. supra* note 77. Physicians working for Group Health Association, the prepayment group practice plan of federal employees, were also expelled from the District of Columbia Medical Society for practicing "contrary to sound public policy." See *Indictment, United States v. American Medical Association*, 28 F. Supp. 752 (D. D. C. 1939). The International Harvester Company case is especially significant because appeal was taken to the American Medical Association Judicial Council. The Council found that a prepayment plan, sponsored by a group of local doctors, was furnishing unlimited medical and surgical services to the employees of International Harvester without solicitation of patients and allowing patients free choice in selecting from the group's staff. See *Record, United States v. American Medical Association*, 28 F. Supp. 752 (D. D. C. 1939) 253-57. The expulsion of the plan's physicians was nevertheless upheld on the ground that "practice under the terms which and conditions to which these appellants have agreed with the employees of International Harvester Company constitutes . . . contract practice contrary to sound public policy." *Id.* at 257.

83. *Id.* at 1032, 866.

the objection voiced against Group Health Association that it would "materially diminish the income of physicians in private practice"⁸⁴ illustrates the apparent economic connotations of the concept. The power to regulate professional conduct seems to have been turned into an instrument for foisting on the public and the profession the AMA's notions of medical economics. Thus, only large and well-established health plans, capable of maintaining their own sizeable clinics and staffs, have been able in the past to withstand AMA sanctions. The possibility of judicial review of organized medicine's actions should, therefore, be considered.

Judicial relief might be available to an expelled physician by way of mandamus for reinstatement to medical society membership.⁸⁵ First, the physician would have to exhaust remedies available within the AMA system, by appealing from local and state units to the AMA's Judicial Council,⁸⁶ unless those remedies could be shown to be vain form.⁸⁷ From the society he could then resort to the courts, alleging a tort based on destruction of his relation with the society, resulting in consequences sufficiently serious to warrant equitable protection.⁸⁸ Initially, however, exceptional judicial hesitancy to intervene in the internal affairs of non-profit associations would have to be overcome.⁸⁹ To surmount this reluctance, the physician could show that judicial restraint has varied appreciably with the purpose and nature of the association and the

84. *Id.* at 932-33.

85. The doctor might also sue for money damages or libel and slander, alleging an unlawful conspiracy and boycott. *Cf. Pratt v. British Medical Association* [1919] 1 K. B. 244. But proof of malice, necessary to such a suit, would be difficult. *Cf. Thompson v. New South Wales Branch of British Medical Association* [1924] A. C. 764 (P. C.).

86. *Irwin v. Lorio*, 169 La. 1090, 126 So. 669 (1930) (expulsion of physicians under contract with Stanacola Employees' Medical & Hospital Association); *Weyrens v. Scotts Bluff County Medical Soc.*, 133 Neb. 814, 277 N. W. 378 (1938); *People ex rel. Wilson v. Medical Soc.*, 84 Hun 448, 32 N. Y. Supp. 415 (2d Dep't 1895); *cf. Baltimore Lodge v. Grand Lodge*, 134 Md. 355, 106 Atl. 692 (1919). See POUND, *CASES ON EQUITABLE RELIEF AGAINST DEFAMATION AND INJURIES TO PERSONALITY* (Chafee ed. 1930) 96.

87. Compare *Gardner v. East Rock Lodge*, 96 Conn. 198, 113 Atl. 308 (1921); *Edrington v. Hall*, 168 Ga. 484, 148 S. E. 403 (1929) (union tribunal obviously biased); *Harris v. Geier*, 112 N. J. Eq. 99, 164 Atl. 50 (1932) (appeal to union dispensed with because of uncertain time and place of the sitting of union tribunal); Note (1922) 31 YALE L. J. 328.

88. For a discussion of the nature of the members' cause of action, see generally Chafee, *The Internal Affairs of Associations Not For Profit* (1930) 43 HARV. L. REV. 993, 995-1010.

89. Compare *Smith v. Kern County Medical Association*, 19 Cal. (2d) 263, 269, 120 P. (2d) 874, 878 (1942) ("Courts may not . . . properly declare that such an association may not expel a member who persists in practice which by rules of the society and the written agreement of the member himself are unethical."); *Porter v. King County Medical Soc.*, 186 Wash. 410, 58 P. (2d) 367 (1936), 36 COL. L. REV. 1371; see *Harris v. Thomas*, 217 S. W. 1068, 1077 (Tex. Civ. App. 1920; see also *Stafford, Disputes Within Trade Unions* (1936) 45 YALE L. J. 1248, 1260.

consequences attendant upon expulsion from it. Thus, courts have refused to review actions of secret societies and churches because of difficulty in mastering their complex rituals and procedural rules,⁹⁰ while fear of widespread public resentment has deterred judicial intervention in the internal affairs of powerful bodies like the Roman Catholic Church.⁹¹ On the other hand, relief against action by organizations with a stranglehold on an industry has been granted—as in cases reinstating workmen to trade unions⁹² and brokers to stock exchange membership⁹³—upon a showing that expulsion deprives the member of the means of making a livelihood rather than of mere social companionship.⁹⁴ By analogy, the disastrous financial consequences of expulsion to the physician afford strong argument for like judicial intercession in these cases.

Once judicial reluctance to exercise jurisdiction is overcome, the court may be persuaded to adopt one of two approaches to reinstate improperly expelled physicians.⁹⁵ Either the society's by-laws may be deemed not violated by the physician⁹⁶ or the rules themselves may be held invalid because contrary to public policy.⁹⁷ The latter contention would probably be more fruitful, since courts weigh heavily a society's interpretation of its own rules.⁹⁸ In challenging the validity of the by-laws, the court might well balance against the claimed benefits of the society its indiscriminate attacks on socially desirable experimentation with group health plans. Similarly, the by-laws' validity might also be challenged by the physician's employer, in suing the society for inducing breach of his contract with the physician.⁹⁹

Strong support for deeming medical society rules against public policy might be found in the recent anti-trust prosecution of the American Medical Association and the local District of Columbia society for conspiring to restrain trade in violation of section three of the Sherman Act. The indictment charged defendants with restraining local physicians "in the lawful pursuit of their

90. Compare *Wellenvoss v. Grand Lodge*, 103 Ky. 415, 45 S. W. 360 (1938). See Pound, *Equitable Relief Against Injuries to Personality* (1916) 29 HARV. L. REV. 640, 680, n. 112.

91. Chafee, *supra* note 88, at 1026.

92. See Stafford, *supra* note 89, at 1261-62.

93. *Weinberg v. Inglis*, [1919] A. C. 606, *aff'g* [1918] 1 Ch. 517; *Casel v. Inglis*, [1916] 2 Ch. 211.

94. See generally Chafee, *supra* note 88, at 1020 *et seq.*

95. See generally Note (1938) 47 YALE L. J. 1193, 1198-99.

96. This was the physician's unsuccessful contention in *Smith v. Kern County Medical Association*, 19 Cal. (2d) 263, 120 P. (2d) 874 (1942); *Bryant v. District of Columbia Dental Soc.*, 26 App. D. C. 461 (1906).

97. See Note (1938) 47 YALE L. J. 1193, 1199, n. 42.

98. Compare cases cited in note 96 *supra*.

99. This was the basis of the cause of action in *Porter v. King County Medical Soc.*, 186 Wash. 410, 58 P. (2d) 367 (1936). The court, however, upheld the action of the medical society, deeming the society's by-laws a contract between member and society enforceable by court. But see (1936) 36 COL. L. REV. 1371.

calling," and hospitals and Group Health Association in the operation of their business, and with denial to the public at large of benefits resulting from more economical medical services.¹⁰⁰ The district court, upholding the defendants' demurrer, sustained their contention that the practice of medicine is not a "trade" as the term is used in the Sherman Act.¹⁰¹ The court of appeals reversed, holding that at common law "restraint of trade" embraced not only commercial activity but the practice of medicine as well.¹⁰² The case was then remanded to the district court, where defendants were convicted. On appeal, the court of appeals, reiterating its prior ruling, upheld the conviction.¹⁰³ The Supreme Court, granting certiorari on AMA's petition, affirmed.¹⁰⁴ Impliedly rebuking the district court for its over-concern with definition, Mr. Justice Roberts thought the "calling or occupation of . . . defendants . . . immaterial if the purpose and effect of their conspiracy was such obstruction and restraint."¹⁰⁵ The Court also rejected defendants' contention that their activities were within the exemptions to the Sherman Act provided by the Clayton and Norris-La Guardia Acts, declaring that this was not a "dispute concerning terms or conditions of employment."¹⁰⁶

Certain jurisdictional difficulties, however, limit the direct application of this decision to other health plans opposed by the AMA. Medical practice in itself has not yet been declared in interstate commerce, ordinarily a prerequisite to suit under the Sherman Act. This requirement is specifically exempted under section three for an action brought in the District of Columbia. In other cases, however, jurisdiction would presumably be very difficult to obtain and any action would have to rest upon state anti-trust legislation. In the construc-

100. See Indictment, *United States v. American Medical Association*, 28 F. Supp. 752 (D. D. C. 1939); Hamilton, *Medicine and the Antitrust Act* (1941) 5 *CONN. STATE MED. J.* 873, 874.

101. 28 F. Supp. 752 (D. D. C. 1939).

102. 110 F. (2d) 703 (App. D. C. 1940), *cert. denied*, 310 U. S. 644 (1940).

103. *American Medical Association v. United States*, 130 F. (2d) 233 (App. D. C. 1942).

104. *American Medical Association v. United States*, 317 U. S. 519 (1943). The Supreme Court's certiorari was limited to three questions: whether the practice of medicine and the rendering of medical services are "trade" under section three of the Sherman Act; whether "restraint of trade" was charged and proven; and, finally, whether a dispute concerning trade and conditions of employment under the Clayton and Norris-La Guardia Act was involved so as to immunize petitioners from prosecution under the Sherman Act. All three questions were decided against the petitioner.

105. 317 U. S. 519, 528 (1943).

106. 317 U. S. 519, 533-36 (1943). In reply to petitioner's claim that the indictment, in five paragraphs, charged five conspiracies, thereby entitling petitioner to have the trial court rule upon the sufficiency in law of each charge, the Court, holding that the five charges were merely different steps toward the accomplishment of the same aim, ruled that the general verdict could stand. As to the sufficiency of proof to sustain the charge, the Court merely noted that the petitioners challenged only the sufficiency in law of the indictment, and that they hardly suggested a lack of evidence to sustain the offense if any was charged in the pleadings. *Id.* 529-33.

tion of such legislation, containing sometimes language different from the Sherman Act, the Supreme Court's decision, though not controlling, may be highly persuasive.

Ultimately, however, assuring free experimentation with group health plans will necessitate a change in organized medicine's stubborn opposition. For, while judicial intervention may serve as a temporary expedient, the group health movement cannot succeed against a hostile profession. Preferably, the change in attitude should come from within the profession itself with a minimum of outside compulsion. To this end, democratization of the AMA's political system, to make medical leadership more responsive to the profession, is indispensable. For as the AMA's political process functions at present, control is centralized in the hands of an active unrepresentative minority, anxious to protect its vested interest in traditional medico-economic institutions.¹⁰⁷ Although the system is organized as a series of democratic assemblies, with power formally running upward from local through state society to the AMA House of Delegates, the prevalent conception of hierarchial control has centralized power in the national organization. And not only are the delegates to the latter physicians of established position economically, often with interests essentially different from those of their constituents, but, further, the House has lost its policy forming function to reference committees, controlled by a few key men who for many years have held the strategic AMA offices.¹⁰⁸ A virtual monopoly of medical literature has in turn enabled this entrenched minority to foist, by effective propaganda, its medico-economic policy on an apathetic profession. Thus, free threshing out of professional opinion in matters of economic reform has been discouraged, in an attempt to present to the public an artificial front of professional ideological unanimity.¹⁰⁹

But if internal self-reform should fail, government intervention in organized medicine appears probable. The AMA's excellent record in maintaining educational standards, quack hunting, and disseminating scientific knowledge may, then, be forgotten and the whole organization destroyed under external public pressure as well as by internal dissidence. There are indications, however, of change in AMA attitude toward group health. While a decade ago it denounced group practice and group prepayment as ". . . socialism and communism—inciting to revolution,"¹¹⁰ the prepayment principle has been officially approved provided it is not joined with group practice, and today there are

107. See generally the excellent discussion in GARCEAU, *THE POLITICAL LIFE OF THE AMERICAN MEDICAL ASSOCIATION* (1941), especially c. III. For violent attacks on the AMA, see RORTY, *op. cit. supra* note 75, 98-110; SHADID, *op. cit. supra* note 77, 201-19.

108. See generally GARCEAU, *op. cit. supra* note 107, 68-96.

109. See BERNHEIM, *MEDICINE AT THE CROSSROADS* (1939) 231: "More serious than [the] lack of strong, integrated leadership . . . is the fact that organized medicine has left no place for the discussion, in open meeting or in its official literature, of social and economic questions as related to medicine."

110. Editorial (1932) 99 *J. AMER. MED. ASS'N* 1950, 1952.

no less than fifteen medical society prepayment schemes in operation.¹¹¹ Nevertheless, the AMA's intransigent opposition to the combining of group practice with prepayment still constitutes a serious impediment to the development of group health plans. Concededly, the organized profession is entitled to voice and prove its objections to group practice. But when its tactics shift from persuasion to coercion and boycott, thus jeopardizing the public's stake in free experimentation—long extolled by the medical profession itself as the very lifeblood of scientific progress—drastic government action would seem inevitable.

CONCLUSION

Wide experimentation with all types of group health plans must be assured in order to determine the economic arrangements most suitable for distributing medical care to the widely varying groups in the population. The necessary social controls must, therefore, emanate from objective expert sources. Judicial surveillance, based on the "corporate practice" rationalization, should be reduced to a minimum because of its unskilled and non-continuous character. The great bulk of the regulatory task should, then, fall upon expert public and professional bodies. Public agencies may well supervise educational competence, financial solvency, and, to some extent, medical standards. In view of the highly personal and fiduciary nature of the service, however, ethical control of the practitioner's conduct by a professional organization would also seem desirable. Yet, the stubborn opposition to economic reform of the present non-representative leadership of the organized profession has cast grave doubt on the possibility of non-economic professional control of standards. Ultimately, however, the scope of professional autonomy in matters of self-regulation will depend on the extent to which its policy conforms with the interest of the community at large.¹¹² If, therefore, unsavory state regimentation is to be avoided, the political process of formulating group opinion must be democratized and medical leadership made representative and responsive to its constituency. Clearly, this will compel a profession enmeshed in its technology¹¹³ to awaken to its sociology, conscious that it will perform its function of preserving the common health only when its far-reaching scientific discoveries are translated into service.

111. See Fishbein, *Medical Plans for Low Income Groups* (1940) 26 A. B. A. J. 149, 150.

112. See generally the penetrating study of the relation of a professional group to the community in CARR-SAUNDERS & WILSON, *THE PROFESSIONS*, especially at 471-89; see also Jaffe, *Law Making by Private Groups* (1937) 51 HARV. L. REV. 201.

113. The profession's lack of interest in sociological matters is well illustrated by Dr. Bernheim's estimate that approximately ". . . 95 per cent of all the material . . . published in the medical periodicals of the United States is concerned with matters professional and scientific . . ." BERNHEIM, *op. cit. supra* note 109, at 234. For a thorough study of professional opinion, see AMERICAN FOUNDATION, *AMERICAN MEDICINE* (1937).