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Group Health Plans A Twenty-Year Legal Review A Twenty-Year Legal Review

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The financial side of medical practice—commonly called "medical economics"—has seen many innovations and changes in the past twenty years, as organizations of people have pressed for better methods of meeting the rising costs of modern medical care. Along with these changes have come notable adjustments in the law, illustrating again in a relatively new field, the adaptibility of law to social changes.

A scant twenty years ago there was little more than an inarticulate desire for more access to health care, but progress in this field was inevitable. Man’s quest for security in life, beyond the basic necessities, will probably never be satisfied. Having acquired a social security system for protecting his income, at least to some extent, it was natural for the wage earner to seek the means for protecting his most important asset—his health. He was aware that modern medical care was highly capable of such protection, but only at costs that were completely unpredictable and often beyond his means.

Organized labor took the lead in attempting a solution in 1939, in the form of a proposal for national health insurance. Organized medicine, sensing a major threat to its traditional mode of practice, responded in two ways. It resisted the proposal in Congress, and also, as a means of helping meet the demand while at the same
time preserving its fee-for-service system, it obtained enactment by state legislatures of so-called "Blue Shield" enabling acts, giving it control of prepayment mechanisms in most of the states.  

As organized labor was losing its program of health legislation, it was obtaining health and welfare funds at the bargaining table. Following the pattern of group health plans, it began to use more and more of these funds in providing direct-service medical care for its members. This development posed a new problem for organized medicine, since large and important lay groups now had the potential for competing with its fee-for-service system on a large scale.

Control by laymen of the means of paying the costs of medical care carries with it the means of arranging with the participating doctors a negotiated method of compensation; for example, salary, capitation, or guaranteed income, which—unlike fee-for-service—produces a predictable annual cost, an important consideration for administrators of these health funds. Further, control of the funds makes it possible to provide comprehensive medical care by coordinating all the facets of modern medicine; for example, a medical

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3. See pp. 531-34 infra.
4. Labor health and welfare funds are governed by the Labor Management Relations Act, 1947, 61 Stat. 157 (1947), 29 U.S.C. § 186(c) (5) (A) (1956) which provided that such funds shall be held "in trust for the purpose of paying, either from principal or income or both, for the benefit of employees, their families and dependents, for medical or hospital care . . ." and that the trust shall be administered by representatives equally from the employer and employees, and a neutral umpire.

"The amounts now going into these health and welfare plans, exclusive of those going into pension programs, life insurance and temporary disability plans, total more than $1,250,000,000 a year." Cruikshank, Labor's Special Interest in Medical Care, 257 New England Journal of Medicine 866 (1957).

5. A "group health plan" as used here means a lay-sponsored (as opposed to doctor-sponsored), nonprofit corporation, association or trust providing medical services, usually comprehensive in nature, to its members, subscribers or beneficiaries, the cost being paid in advance by individual periodic prepayments, or through labor health and welfare funds, the services being rendered by doctors appointed to a panel or medical staff, usually balanced to include the specialties, and the compensation to the doctors being on some mutually agreeable basis, such as salary, capitation or some form, other than fee-for-service, which is budgetable as cost that is more or less fixed. The most common types are the voluntary membership associations like Group Health Association of Washington, D.C., or the labor health plans like the A.F.L. Medical Center at Philadelphia and the United Mine Workers' plans throughout the country (the latter, for example, expending annually almost fifty million dollars of health and welfare funds for hospital and medical care of miners and their families). See Group Health Federation and Its Member Plans (1955) procurable at the federation offices, 343 S. Dearborn Ave., Chicago, Ill.

6. A resolution adopted at the first convention of the merged AFL-CIO stated in part that the common main objective of all health and welfare plans is "to make available to the members the maximum in terms of actual prepaid health services, as distinguished from cash payments . . ." (Emphasis added.) See also 257 New England Journal of Medicine 866 (1957).
staff of balanced skills, a variety of diagnostic and therapeutic equipment, and the necessary array of technicians. Such coordination is difficult to achieve at best, and would be impossible without an adequate source of funds, singly administered.

While such use of labor health and welfare funds is designed to place more and better medical care within the reach of the wage earner, organized medicine sees it rather as an economic threat to the status quo. This view is understandable. A group health plan providing comprehensive care on a nonprofit basis removes the fear of a crushing medical debt which the fee-for-service system might sometimes produce. This fact, along with the other advantages of controlling medical dollars, gives group health plans great appeal.

Organized labor has seen these advantages and is pursuing them. Considering that health and welfare funds are provided for in almost all labor contracts, that they are growing in size, and involve many millions of wage earners, together with the fact that labor leaders are applying more of these funds to group health plans, it may readily be seen that here is the greatest challenge to the fee-for-service system that the medical profession has yet faced.

Organized medicine is firmly committed to fee-for-service and has long realized that it can best prevent inroads into this system to the extent that doctors, rather than laymen, control medical dollars. Its answer for this purpose is the "Blue Shield" plan, uniformly under control of doctors by nature of the special state acts under which they operate. Blue Shield plans offer prepayment and free choice of doctor, as opposed to a panel of doctors in a group health plan. But because of unpredictable fee-for-service costs the medical care offered is necessarily limited, in many cases to surgery, in-hospital emergency, and maternity care.

While Blue Shield plans are serving some labor health and welfare funds, particularly because they are adaptable to a wide geographic area, their limitations of coverage leave much to be desired. Yet, they do provide at least a partial solution to the problem of budgeting for medical care, and do have wide public acceptance. Their importance to this discussion is their role in preserving the fee-for-service system as the exclusive means of access to medical care.

7. See note 1 supra.

8. See Means, op. cit. supra note 1 at 185, 186. "I believe that payment for medical care on a fee-for-service—as-rendered basis is outmoded. It is not conducive to the best care of patients in present-day society. Instead I believe that prepayment plans, which afford benefits directly in the form of comprehensive service, are today the method of choice."
If the contest between professional and lay groups for control of medical dollars were limited to ordinary, free competition between group health and Blue Shield plans, this discussion would be unnecessary. But the competition is neither ordinary nor free. Organized medicine possesses the means of purveying the indispensable medical care without which neither system would work, and it has not hesitated to restrict availability of medical care as a means of eliminating competition to its traditional mode of practice. This restriction has been effected by certain legal or ethical devices.

The legal devices include obtaining special state legislation in the form of restrictive Blue Shield acts, asserting the common law prohibition against corporate practice of medicine, and claiming violation of state insurance statutes.

The ethical device employed is denial of membership by a medical society to a doctor who participates in a group health plan, usually on the grounds that he is a party to a solicitation scheme or to denial of free choice of doctor, both being so-called "ethical" principles. Such discipline has salutary effect because of its great harm to the doctor's reputation, and its effectiveness as an economic weapon in eliminating the competition of a group health plan, which finds it difficult to interest doctors in participation when they face professional ostracism.

Use of these devices began in earnest twenty years ago and gave rise to the famous Group Health cases. It has continued with little letup and, with the recent activity on the part of organized labor, has become more intense than ever. Organized medicine is again engaged in restrictive activities to stem the tide, and it may be expected that a new rash of lawsuits will follow. The outcome will undoubtedly have profound effect on the future distribution of medical care in this country.

Whatever the outcome, it is certain to be influenced by the re-

10. These cases involve the harassment by the local medical society of a voluntary plan whereby federal employees in the District of Columbia provided themselves with medical services by a prepayment system. See Group Health Ass'n v. Moor, 24 F.Supp. 445 (D.C. 1938), aff'd sub nom, Jordan v. Group Health Ass'n, 107 F.2d 239 (D.C. Cir. 1939); United States v. A.M.A., 110 F.2d 703 (D.C. Cir. 1940), aff'd, 317 U.S. 519 (1943).
11. The 1957 annual meeting of the House of Delegates of the A.M.A. considered many resolutions from delegations of state medical associations complaining about the activity of labor health plans and calling on the A.M.A. nationally to take a strong stand against them by way of declaring them "unethical," mainly on the ground that they did not conform with the free-choice-of-doctor and fee-for-service system. See 164 A.M.A.J. 1231-45 (1957). Apparently wiser legal heads at this convention prevailed and these resolutions were not adopted as being "unenforceable." See Time Magazine, June 17, 1957, at p. 40.
markable body of law emerging from this conflict in the past twenty years. It is the purpose of this article to review this law and to observe its effects upon the growing competition in the field of medical economics. Special attention will be given the anti-trust aspects because of the increasing use of discipline against doctors who participate in group health plans, as a means of eliminating competition from that source.

I. STATE ENABLING LEGISLATION

The power to regulate conduct concerning the public health is reserved to the states. Those statutes which license doctors and hospitals are prime examples of the exercise of this power by state legislatures. On the federal level, there were attempts in Congress beginning in 1939 to enact national health insurance, but the bills for this legislation were not regulatory and merely proposed a means of financing health care under existing modes of medical practice. The strong opposition to these proposals from organized medicine came from fear that ultimately the control of medical dollars would slip from its hands into those of the government. This fear was so strong that, although organized medicine had so recently opposed "Blue Cross" plans for prepaying hospital care, it now hastened to organize "Blue Shield" plans for prepaying medical care. Recognizing the sovereignty of the states in these matters, it sought and obtained from the state legislatures unique enabling acts for these plans.

These acts, with few exceptions, are restrictive in nature, in that they limit administrative and economic control of prepayment plans to the medical profession, to the exclusion of lay groups. While the primary purpose of these acts is to control medical dollars, they also secure exemption from the insurance laws and the corporate practice rule.

A study through the 1957 legislative sessions shows that forty states have adopted such enabling acts. Twenty-six states have a restrictive type, meaning that in one form or another the administration, including economic aspects, of a prepayment medical care

12. See also Hansen, Laws Affecting Group Health Plans, 35 Iowa L. Rev. 209 (1950); Notes, Cooperation in Medicine, 35 Minn. L. Rev. 373 (1951); The American Medical Association: Power, Purpose, and Politics in Organized Medicine, 63 Yale L.J. 937, 976-95 (1954).

plan is given to the control of the doctors.\textsuperscript{14} Four other states which have restrictive laws have enacted parallel, separate acts authorizing similar corporations to be formed for the operation of prepayment plans by lay groups.\textsuperscript{15} Two states give limited authority to lay plans.\textsuperscript{16} Eight states have open acts which give authority alike to doctor and lay-sponsored plans.\textsuperscript{17} The remaining eight states have no enabling legislation of any kind.\textsuperscript{18}

Restrictive state legislation was the subject of a recent lawsuit in California between a group health plan and the local medical society.\textsuperscript{19} The members of the medical society participated in the statewide “Blue Shield” plan sponsored by the state medical association under a restrictive act which provided that at least one-fourth of all doctors in the state must participate and that all doctors must be eligible to do so. The group health plan had a small staff of doctors serving a membership in San Diego and obviously could not comply with such requirements. This particular health plan was incorporated under the general nonprofit act and was in competition with the Blue Shield plan. Its doctors were ostracized by the medical society, which was the immediate basis for the lawsuit.

\begin{footnotesize}
\begin{enumerate}
\item Control by doctors results from provisions in these acts which require that the incorporators or the majority of the governing board be doctors, or that selection of directors be approved by the state medical association, or that a substantial percentage or all the local doctors be actual or eligible participants. Lay-sponsored plans obviously cannot satisfy such requirements.
\end{enumerate}
\end{footnotesize}
At the trial the medical society tried to show, in justification of its disciplinary action against these doctors, that they participated in a plan which was not complying with the special (restrictive Blue Shield) act. The Supreme Court of California stated that this act was permissive, not mandatory, and if it “should be held to be the only section under which a nonprofit medical service corporation may incorporate, CPS [California Physicians Service—Blue Shield] might exercise a monopoly in that field and thus raise other legal problems.” The legality of the group health plan was upheld.

This decision is cited with approval in a 1955 opinion of the Attorney General of Minnesota involving a similar fact situation, which states that:

The proposed corporation is not one which comes within the scope or meaning of Chapter 159 [Blue Shield Act] as it appears upon the face of the Articles of Incorporation that the members and incorporators are not doctors of medicine and that the basic purpose of the corporation is to provide a means for patients to organize for the purpose of securing medical and dental care for themselves, their families and dependents, rather than for doctors to organize for the purpose of offering their services to patients as is contemplated by Chapter 159. It is, therefore, apparent that the proposed corporation is not within the scope or contemplation of Chapter 159.

It should be noted that the Minnesota “Blue Shield” act is permissive in nature, stating that “nonprofit medical service plan corporations hereinafter incorporated may be organized under and in accordance with the provisions of this chapter by not less than 21 persons, all of whom shall be legal residents of this state and duly licensed and registered doctors of medicine under the laws of this state.”

In contrast, the Michigan “Blue Shield” act is mandatory in nature, and states that “no non-profit medical care corporation may be incorporated in this state except under and in accordance with the provisions of this act. . .” However, an opinion of the Michi-
gan Attorney General holds that the control provision of this act, which provides that the majority of the directors of the corporation shall be approved by the state medical association, is unconstitutional as being "vague." It would seem that such a provision might also be held to be unconstitutional on the grounds that it is (a) class legislation since it purports to give one segment of the population exclusive economic privileges, and (b) an unlawful delegation of administrative authority to a private organization, in this case the state medical association.

A twenty-year survey shows no social or legal justification for such restrictive legislation. On the contrary, in an economic area where experimentation is desirable, such legislation tends to retard progress in the search for better ways to provide access to modern medical care, which yearly becomes more complicated and expensive. A Blue Shield act wherein organized medicine says in effect—"you may have access to medical care by prepayment, but only upon our terms and at our fee-for-service price, and no other method may be the subject of negotiation"—is not in keeping with free enterprise and democratic process, and does not become the medical profession, which prides itself on a scientific attitude in searching for answers to strictly medical questions.

Thus, it appears that legal existence should not be denied a group health plan which is properly operating under a general nonprofit corporation act. The presence of a permissive type Blue Shield act does not preclude it, while the mandatory type appears vulnerable to attack on constitutional grounds.

II. THE COMMON LAW RULE AGAINST CORPORATE PRACTICE

The "corporate practice rule" prohibits a corporation from furnishing medical services for fees through doctors engaged and paid by it. The rule, which is followed in a majority of the states, is usually grounded upon considerations of public policy, medical licensing laws, or professional standards. However, this view is based largely upon cases involving plans engaged in the selling

of doctors’ services to the public for a profit,\textsuperscript{30} while group health plans render doctors’ services to their members on a non-profit basis, thus distinguishing them from the rule.\textsuperscript{31}

This distinction has been made abundantly clear in a number of recent decisions. In the first one, twenty years ago, the California Supreme Court invoked the rule against a corporation which sold the services of hired doctors to the public for a profit to its stockholders. However, the court took great care to explain that it would not apply the rule to a nonprofit corporation. The court pointed out that the two types of activities are not comparable and that “since the principal evils attendant upon corporate practice of medicine spring from the conflict between the professional standards and obligations of the doctors and the profit motive of the corporation employer, it may well be concluded that the objections of policy do not apply to nonprofit institutions.”\textsuperscript{32}

The California court underscored this distinction in a later case involving a nonprofit group health plan which arranged medical services for its members through a panel of doctors acting as independent contractors. The local medical society had boycotted the plan and refused membership to the plan’s doctors. In trying to justify this conduct, the medical society made the assertion, among others, that the plan was illegally engaged in the corporate practice of medicine. The court rejected this assertion and stated that “this principle is not contravened by permitting a group of interested persons to form a nonprofit corporation to secure for themselves medical services at a low cost.”\textsuperscript{33}

A Washington state court found that a medical society in a similar fact situation was in violation of the anti-trust laws and, that in asserting its affirmative defense of unclean hands on the part of the group health plan, had “failed to establish that the Cooperative is operating for profit and therefore ultra vires.”\textsuperscript{34}

In the earliest of the \textit{Group Health} cases the main issue was whether a nonprofit corporation in arranging for a medical group to furnish medical services to its members was practicing medicine in violation of the medical licensing statute. The federal district

\textsuperscript{31} United States v. AMA, 110 F.2d 703, 714 (D.C. Cir. 1940), aff’d, 317 U.S. 519 (1943).
\textsuperscript{32} People \textit{ex rel. State Board of Medical Examiners v. Pacific Health Corp.}, 12 Cal. 2d 156, 160, 82 P.2d 429, 431 (1938).
\textsuperscript{34} 39 Wash. 2d 585, 663, 257 P.2d 737, 778 (1951).
court found it was not, and stated: "Such a corporation, not for profit, but for the mutual benefit of its members, is in my opinion not engaged in the practice of medicine or in holding itself out as doing so."35

The harassment of this Washington, D.C., group health plan by organized medicine led to the criminal prosecution of the American Medical Association and others under the Sherman Act. The defendants attempted to justify their conduct on the ground that the plan was engaging in corporate practice of medicine. In disposing of this defense on appeal, the circuit court stated: "But in all the cases we have examined in which the practice has been condemned, the profit object of the offending corporation has been shown to be its main purpose. . . ."36

The view that the criterion for applicability of the rule is whether the corporation is nonprofit in character is supported by recent opinions of the Attorney General of Minnesota37 and North Carolina.38

The corporate practice rule is a legal fiction which the courts have adopted to deal with profit-taking schemes that adversely affect the health of an untutored public. In the absence of applicable legislation or a clear right of the executive to put down quackery or commercialization of medicine, the courts apparently have felt justified in creating the rule to protect the public health. However, when nonprofit plans came to the attention of the courts, they saw in them none of the social evils which gave rise to the rule, and a proper distinction was drawn. No case has been found where the courts have applied the rule against a nonprofit, consumer-sponsored, prepayment medical service corporation—commonly known as a group health plan.39

III. APPLICABILITY OF THE INSURANCE LAWS

Many state insurance codes define the business of "insurance" so broadly that at first blush it would seem to cover a group health plan. The factors in the usual definition include periodic payments

36. United States v. AMA, 110 F.2d 703, 714 (D.C. Cir. 1940), aff'd, 317 U.S. 519 (1943). (Emphasis added.)
39. In all of the actions by a group health plan against a medical society, the latter raised the question of corporate practice against the plan. See pp. 538-46 infra.
for the coverage, the delivery of money or something of value on the happening of stated contingencies, and an overall plan of sharing risks among the persons covered.

There are, however, many features distinguishing medical service plans from insurance companies, but the decisive factor is that the former is engaged in furnishing services, and the latter in paying cash indemnities. This is illustrated by a case involving a consumer-sponsored plan, wherein the court said:

To summarize, the distinctive features of the cooperative are the rendering of service, its extension, the bringing of physician and patient together, the preventive features, the regularization of service as well as payment, the substantial reduction in cost by quantity purchasing, in short, getting the medical job done and paid for; not, except incidentally to these features, the indemnification for cost after the service is rendered. . . . There is, therefore, a substantial difference between contracting in this way for the rendering of service, even on the contingency that it be needed, and contracting merely to stand its cost when or after it is rendered.

That an incidental element of risk distribution or assumption may be present should not outweigh all other factors.

This same reasoning was applied in a doctor-sponsored plan:

Stated in terms of insurance, all risk is assumed by the physicians, not by the corporation, hence the only effect of requiring compliance with regulatory statutes would be to compel the acquisition of reserves contrary to the established method of operation.

And one court adopted the same attitude to a profit-type plan:

The contract is not one of indemnification. . . . The physicians are engaged and stand ready to render their services. The Company can not be called upon to expend further money than that already paid or agreed to be paid to them. . . . Neither as between the corporation and the physician, nor as between the physician and the subscriber is the compensation or any other element of the arrangement between them affected by any contingency, hazard or risk.

These cases illustrate the majority view of the courts and should be decisive in disposing of any question that a group health

plan is engaged in the insurance business. In addition, there is another practical consideration. In such a plan the doctors are usually paid some type of fixed annual income, so that when this income is added to other fixed overhead items the total annual cost is known in advance and, for all practical purposes, is fixed in advance. The rate of dues payable by the members can easily be calculated to meet this known cost. Thus, there is no need for the establishment of reserves, regulation of rates and other general supervision by a state insurance commissioner, as in the case of insurance companies where losses are not so easily predicted and the possibility always exists that heavy losses might cause insolvency.

IV. ORGANIZED MEDICINE AND THE ANTI-TRUST LAWS

As indicated in the preceding sections, charges that a group health plan is operating in violation of state law have proved ineffectual. More to be feared by sponsors of these plans is disciplinary action by the local medical society against participating doctors. This action consists of expulsion from the medical society if the doctor is a member, or denial of admission if he is not. In either case there is resulting damage to the doctor’s reputation and professional future, serious enough to cause him to consider leaving the plan. If he leaves the plan and others cannot be persuaded to participate for fear of the same consequences, the plan cannot function and its economic competition is thereby effectively destroyed.

a. What is the nature of a doctor’s participation in a group health plan which leads to such disciplinary action?

Simply stated, it is the doctor’s agreement with the plan to accept a form of compensation different from traditional fee-for-service. It may be a stated salary, capitation (stated amount per member-patient per year), or a guaranteed minimum income (to put a floor under an uncertain fee-for-service income). The alleged sin is purely financial and has nothing to do with the moral character or professional competency of the doctor, which are usually the only two requirements for membership in a medical society, as well as for a license to practice.

45. The guaranteed minimum income agreement is used primarily to attract a doctor to a new location. For example, in Colorado the trustees of a labor health and welfare fund induced two needed specialists by such an agreement to locate in a mining town, in order to improve the quality of medical care rendered its beneficiaries. The local medical society, consisting of eight general practitioners, resented this new competition and tried to remove it by denying membership to the two doctors. An anti-trust action resulted and was filed in the state district court at Trinidad, Colorado, in November, 1957.
b. What are the consequences of such disciplinary action?

A doctor who cannot get membership in a medical society is usually professionally and socially ostracized by his medical colleagues. He may be excluded from privileges by hospitals which require society membership. He may be shunned by specialists whom he may call upon for consultation. If he is eligible by training to obtain specialty board certification, he may find it difficult to obtain such a certificate. His malpractice insurance may cost more. Since a layman associates non-membership with quackery, he will be under a cloud with his patients. When he is cut off from professional contacts he is less able to keep up with the progress of medical science. All of this adds up to serious damage to his reputation and his income.

c. What is the remedy?

The anti-trust laws afford redress against these disciplines, by way of injunction and damages. In cases under the Sherman Act, criminal penalties are added. Whether the action is brought under the federal act, or under state law in the form of a constitutional provision, a statute, or the common law, its nature is the same. All anti-trust law fundamentally has its roots in ancient concepts of the common law.

In the cases that have involved group health plans, the motivation for the disciplinary action was economic in nature: to eliminate competition to the traditional fee-for-service mode of practice. Such restraints are no different in the eyes of the law from those imposed by economic organizations, if the purpose or the result is to lessen or destroy competition. In one case the combination practicing unlawful restraint is a medical society, in the other a business group. Both are equally reprehensible. As stated in the leading case on this subject by the federal circuit court, such disciplinary action

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46. There is authority supporting the discretionary right of private hospitals to exclude doctors from privileges. See Group Health Cooperative v. King County Medical Soc'y, 39 Wash.2d 586, 667, 237 P.2d 737, 780 (1951). A distinction is made as to public hospitals supported by tax funds. Id. at 668-69, 237 P.2d at 780-81. However, note that the action of the society that precipitated the criminal prosecutions against organized medicine in United States v. AMA, 110 F.2d 703 (D.C. Cir. 1940), aff'd, 317 U.S. 519 (1943), was the enlisting of hospitals to deny privileges to Group Health's doctors. See The American Medical Association: Power, Purpose, and Politics in Organized Medicine, 63 Yale L.J. 937, 991 (1954).

47. In Group Health Cooperative, supra note 46, the Supreme Court ordered a mandatory injunction and retained jurisdiction for three years to assure admission of the disciplined doctors to the medical society.

48. E.g., United States v. AMA, 110 F.2d 703 (D.C. Cir. 1940), aff'd, 317 U.S. 519 (1943).
“is just as much in restraint of trade as if it were directed against any other occupation or employment or business. And, of course, the fact that defendants are physicians and medical organizations is of no significance." On final appeal of this case, the United States Supreme Court approved this conclusion and stated:

As the Court of Appeals properly remarked, the calling or occupation of the individual physicians charged as defendants is immaterial if the purpose and effect of their conspiracy was such obstruction and restraint of the business of Group Health.49

In upholding the conviction of the American Medical Association, the Supreme Court found that the motivations behind the disciplines were purely economic and that the purpose was "to prevent Group Health from functioning."

This case was brought under the Sherman Act, which is largely a codification of the common law. In the more recent case of Group Health Cooperative v. King County Medical Soc'y,51 also involving disciplinary action by a medical society against Group Health's doctors, the action was brought under state law. In that case, the Supreme Court of Washington stated:

At the common law, the term "restraint of trade" was deemed to cover the practice of medicine. . . . [citing cases] The corporate activity of offering, entering into, and performing contracts providing for prepaid medical service, is also a business or trade at common law. . . .

As our constitutional provision bespeaks the common law, so it should be permitted to afford the same protection and serve the same broad public interest which is available at common law. Monopolies affecting price or production in essential service trades and professions can be as harmful to the public interest as monopolies in the sale or production of tangible goods.52

Then, commenting upon the medical society as a "combination" in unlawfully restraining Group Health Cooperative, the court continued:

There can be no question but that the purpose of the combination in the instant case is to pre-empt and control all contract medicine practice in King County. If respondents [medical society and others] are successful in this effort, there will be no competition in the contract medicine field. Members of the public will have no opportunity to choose between two or more plans offering this type of service. The result will be a complete monopoly of this product throughout the country.53

49. Id., 110 F.2d at 711.
50. Id., 317 U.S. at 528.
52. Id. at 638, 237 P.2d at 765.
The applicability of anti-trust law to disciplinary actions of medical societies goes back to English common law. The leading case of *Pratt v. British Medical Ass'n*, brought under the common law, was cited with approval in both *United States v. AMA* and the *Group Health* case. The *Pratt* case involved medical society discipline against doctors on the staff of a group health plan called Coventry Dispensary, which provided medical care to its 20,000 subscribers who paid it annual dues. The mode of compensation paid by the plan to the staff doctors deviated from the traditional fee-for-service system, and, as the English court stated:

The alleged sin was financial rather than moral in its character. This was frankly admitted by several of the defendants' witnesses. The pecuniary interests of the Coventry doctors lay at the root of the matter. The question of ethics, as that word is ordinarily understood, had nothing to do with the case. The plaintiffs were punished because they defeated the intended overthrow of the Coventry Dispensary. If the Coventry Dispensary had been destroyed as a lay organization, then the local doctors could obviously have taken such steps as would have increased their area of private practice, and their emoluments would have gained a corresponding expansion. This was the fundamental object of the defendants. The nonparticipation in such aim by the plaintiffs was the head and front of their offending.

d. How does a medical society rationalize or justify its disciplinary action?

Such discipline is always exercised in the guise of "ethics." The usual charge is that the group health doctors are parties to a plan which involves (1) solicitation of patients, or (2) denial of the "principle" of free-choice-of-doctor. As will be seen by careful scrutiny, these two "ethics" are neither definitive nor applicable to group health plans, and are merely the excuse for disciplinary action. In the absence of the excuse, of course, the action would be a patent, economic pressure device to destroy competition. However, in view of the invariable use of these "ethics" as justification, they warrant examination.

1. Solicitation of Patients

The *Principles of Medical Ethics of the AMA*, adopted in June, 1957, referring to a doctor's conduct to his patient, ends by saying

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53. Id. at 640, 237 P.2d at 766.
54. [1919] 1 K.B. 244 (1920).
55. 110 F.2d at 710.
56. 39 Wash.2d at 645, 237 P.2d at 769.
57. [1919] 1 K.B. at 272.
in section 5: "He should not solicit patients." Nothing is said about his participation in a plan which advertises by inviting subscribers or members to join. The Judicial Council of the AMA, the "supreme court of medicine," had this question squarely before it in the Landess case, decided early in 1955. There it was found that Dr. Ben E. Landess was a doctor participating in the Health Insurance Plan of Greater New York, a group health plan which advertised. The Council held:

Since on the record before us H.I.P. is organized and operates in accordance with law and may lawfully advertise; since the quality of its advertising is not in issue, and since Dr. Landess had nothing to do with the preparation or distribution of the advertising, it is our opinion contrary to that of the state and county medical societies that the conduct of Dr. Landess does not violate the ethic relating to solicitation and advertising.\(^5^8\)

The arguments for Dr. Landess asserted that the rival Blue Shield plan in New York did far more solicitation by advertising than did H.I.P. and pointed out that the AMA Twenty Principles, points 5 and 10\(^5^9\) specifically authorize advertising by lay-sponsored plans.

In the Group Health Cooperative case, the Washington Supreme Court commented on the charge of the medical society regarding "solicitation" by Group Health, as follows:

There is nothing in the record to indicate that there is any misrepresentation, overselling, or other impropriety with respect to the way in which this soliciting is done. There would seem to be no more objection to such solicitation, from the standpoint of professional ethics or general public interest, than in the case of Service Corporation's [Blue Shield] solicitation. The latter organization engages a force of paid salesmen, and does extensive newspaper and radio advertising in the sale of its industrial contracts.\(^6^1\)

In the Complete Service Bureau case, the California Supreme Court disposed of a similar charge by arguing that solicitation by advertising when done by a health plan, and not the doctor, is not unethical in the eyes of the AMA or against public policy in the eyes of the court. "It is clear that the activities of the nonprofit medical service corporations in securing members is not 'procur[ing] practice for a practitioner...'."\(^6^2\)

\(^{59}\) Ibid.

\(^{60}\) 140 A.M.A.J. 686 (1949).

\(^{61}\) 39 Wash.2d at 614, 237 P.2d at 752-53.

In view of the foregoing it is likely that the ethics against "solicitation" will no longer be asserted. This cannot be said about "free choice," the last remaining excuse for disciplinary action and the one now being used more assertively than ever.\(^6\)

2. The Free-Choice-of-Doctor "Principle"

It will be noted that the *new code*—*Principles of Medical Ethics of the AMA* is silent on this subject.\(^6\) If we assume that the *old code* is to be used as a guide, we note in its pertinent parts, that section 4 of Chap. VII provides that "free choice" may properly be limited if a "third party" has a "valid interest," meaning that it voluntarily assumes the cost of medical care, and that in such cases the plan is not unethical.\(^6\) Section 5 states that participation in any plan is unethical only if financial profit is involved. It will be seen that nothing in these tests makes a group health plan unethical by AMA standards.

Looking further into other AMA "guides," we find that both the *Twenty Principles*\(^6\) and the *Guiding Principles for Union Health Centers*\(^6\) expressly provide for "participating physicians" and "medical staffs," which means panel or group practice and the opposite of "free choice."

In the *Landess* case, the Judicial Council in commenting on the *Twenty Principles* stated that while they are not in the nature of "amendments" to the code of ethics, they "are certainly to be given full consideration in interpreting and applying them."\(^6\)

All of the group health plans that brought actions against medical societies had "closed panel" medical staffs and the merits of this system, as opposed to the free-choice-of-doctor "principle," while not a real issue in any of these cases was discussed and summarily disposed of.

Not only is the "principle" an improper excuse for disciplinary

\(^6\) See note 11 supra.
\(^6\) The entire section reads:
Free choice of physician is defined as that degree of freedom in choosing a physician which can be exercised under usual conditions of employment between patients and physicians. The interjection of a third party who has a valid interest, or who intervenes between the physician and the patient does not per se cause a contract to be unethical. A third party has a valid interest when, by law or volition, the third party assumes legal responsibility and provides for the cost of medical care and indemnity for occupational disability.
\(^6\) See note 60 supra.
action, it is deficient when tested by logic and common sense. For examples:

It assumes that all doctors are equally competent.
It assumes that untutored laymen can make wise choices.
It provides no means for elevating standards and quality of medical care, in fact it lessens the possibility.
It eliminates the possibility, if strictly followed, for any type of panel or group practice of medicine, which many believe is the best way to provide the full blessings of modern medicine.

It is one of the means of selecting doctors, but by no means the only one. Selection of doctors for a panel or group by competent medical consultants on behalf of a group health plan is another method having proven merit.

It is advocated by organized medicine as the only method which results in the patient giving his confidence to his doctor. But often greater confidence results when the patient knows his doctors are selected for him by trusted medical consultants on the basis of competence and skill. This is true not only in lay plans, but also in private clinics such as the Mayo Clinic.

It assumes the patient will be able to pay the bill after making his choice. If the patient cannot pay, then free choice is neither free nor real. If a prospective patient feels he may not be able to pay, he will often delay treatment rather than risk a financial disaster, and in this case “free choice” becomes a mockery.

It precludes prepayment for comprehensive medical care. Free choice harmonizes only with the fee-for-service system, which affords no possibility of predetermining an actuarial basis for complete care. The best that Blue Shield can do is provide limited care because the billings it receives are unpredictable, being based on fee-for-service.

*It is asserted as a “principle” only where lay-sponsored plans are concerned.* Organized medicine at best has a questionable right to champion “free choice” for people who are not asking for it, and who in fact have decided against it in choosing a group health plan with a selected panel.

V. JUDICIAL VIEWS ON MEDICAL ETHICS

When medical societies use disciplinary action as an economic weapon to eliminate competition, the courts denounce it in emphatic terms, and make it clear that indulgence in such conduct will be treated no differently from cases involving private business corpora-
tions. Nothing can be plainer than the right of everyone to require the course of his legitimate occupation to be free from restraint. If this right is violated, the courts will afford redress. And it makes no difference if the combination of individuals or units committing the offense is a medical society, a business group, or a mob on the street. It also makes no difference in the eyes of the law if the combination or conspiracy committing the offense is motivated by economic self-interest or by the loftiest of ethical principles. It is the effect that counts, and if that effect is to restrain a lawful pursuit, to eliminate competition, or to create a monopoly, the courts will afford a remedy.

As the court stated in United States v. AMA: "Under no circumstances could the commission of crime be justified as a reasonable regulation of professional practice." In the Group Health Cooperative case, the court decried the use of ethics for economic purposes and said: "In our opinion, the Society may not, through the mere use of the term 'unethical', clothe with immunity acts which would otherwise fall under the ban of the antimonopoly provision of our constitution." Again, in the Complete Service Bureau case, the court disposed of the ethical assertions of the medical society by stating simply that "none of the policies or activities of [Complete Service Bureau] is harmful, injurious or inimical to the public health or welfare."

Even the AMA on one occasion denounced the use of ethics for economic purposes. The Journal of the AMA on July 16, 1949, editorialized:

Instances have occurred in which physicians, for political, commercial or emotional reasons, have endeavored to utilize the Principles of Medical Ethics as a means of producing embarrassment, distress or loss of reputation of other physicians whom they envy or whose open competition they fear. The Principles of Medical Ethics were not designed for any such purposes, and the attempt to utilize the principles of ethics for such purposes may well be in itself unethical.

Besides the ethical excuses for the use of discipline, medical societies have asserted their "right" as private membership associations to admit or deny membership as they see fit, without judicial interference. The answer of the courts is simply to say that this is true only up to the point where the action is used as an economic weapon. In United States v. AMA, the federal circuit court said:

69. 130 F.2d 233, 244 (D.C. Cir. 1942).
70. 39 Wash.2d at 645, 237 P.2d at 768-69. (Inserts added.)
71. 43 Cal.2d at 217, 272 P.2d at 506.
72. 140 A.M.A.J. 960 (1949). (Emphasis added.)
Defendants say that what they are charged with doing amounts to no more than the regulation of membership in the society and the selection of the persons with whom they [wish] to associate; that under their rules disobedient members may lawfully be disciplined and that disciplination does not amount to unreasonable restraint. This may very well be true, and in considering the contention we are not unmindful of the importance of rules of conduct in medical practice, rules which can best be made by the profession itself. . . . All of which may well be acknowledged to their credit. Notwithstanding these important considerations, it cannot be admitted that the medical profession may through its great medical societies, either by rule or disciplinary proceedings, legally effectuate restraints as far reaching as those now charged.  

How then can organized medicine *legitimately* endeavor to maintain its fee-for-service system against competition from new methods of paying the cost of medical care?  
The courts have made clear that organized medicine is limited, like any other calling or business, to the use of persuasion without force.

In the *Pratt* case, the English court stated:

> Upon considering the rules in question I have arrived at the conclusion that they are in restraint of trade, and are void on the ground of public policy. They gravely, and in my view unnecessarily, interfere with the freedom of medical men in the pursuit of their calling, and they are, I think, injurious to the interests of the community at large. It may well be that the opinion I have just expressed will, if upheld, destroy the cogency of the defendants' scheme of boycott; but it leaves them with the safer and more kindly weapons of legitimate persuasion and reasoned argument.

And, again in *United States v. AMA*, the court stated:

> As we suggested in our earlier opinion, appellants have open to them always the safer and more kindly weapons of legitimate persuasion and reasoned argument, as a means of preserving professional esprit de corps, winning public sentiment to their point of view or securing legislation. But they have no license to commit crime. When they go so far as to impose unreasonable restraints, they become subject to the prohibition of the Sherman Act. *This, then, represents a limit to professional group activities.*

74. 110 F.2d at 711-12.
75. [1919] 1 K.B. at 274-75. (Emphasis added.)
76. 130 F.2d at 248. (Emphasis added.)
VI. Conclusion

In reviewing the past twenty years we find changes in medical economics occurring at an ever faster rate, and find the courts keeping pace with the changes. There is a restless search for better methods to distribute more medical care to more people. The cost grows greater as new discoveries make medicine more complicated, requiring a high degree of coordination between specialties, equipment and technicians. Experimentation in methods of organizing medical services efficiently along with a prepayment mechanism, have succeeded because the latter provides the financial means for achieving the former.77 Group health plans, using such methods, have proved their worth and are spreading. Labor health and welfare funds are giving these plans greater impetus.

As this activity grows there are bound to be increasing conflicts with the traditional mode of medical practice. These conflicts will result in litigation78 and the law reviewed in this article will be basic to the issues. As group health plans find themselves involved in these lawsuits to test anew their right to survival, they will find comfort in the fact that in the past twenty years they have prevailed without exception.

The apparent legal barriers to these plans, which so recently seemed formidable, have been effectively removed. If a group health plan follows in its operations the lessons in this law,79 it should meet no insurmountable barrier.

The common law prohibition against corporate practice of medicine does not apply to a nonprofit plan. The insurance statutes do not apply if the plan provides medical services instead of cash indemnities. The "Blue Shield" statutes, if permissive in nature are no bar to incorporating the plan under the general nonprofit corporation code; if they are mandatory in nature, they may be attacked on constitutional grounds, or avoided by use of an unincorporated structure with adequate safeguards.80

Attacks by organized medicine can be fully met with a strong body of anti-trust law, headed by a decision of our highest court which is undergirded by England's highest court. No sharper rebukes appear in any anti-trust decisions than in those cases where

78. See note 45 supra. In addition to the decided cases cited in this article, recent actions filed in Oklahoma and Minnesota have been settled without trial.
80. Ibid.
organized medicine is taken to task for using ethics as an economic weapon.

All in all, group health plans now have sufficient legal approval to encourage their widespread growth. The same can be said for any other method or experiment which is truly nonprofit, operates by a service motive, and strives only for more distribution of good medical care. The courts traditionally have shown great concern for the public health, and by their decisions have indicated great impatience with any interest standing in the way of its betterment.