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Medical Clinics: Legal and Political Structure in Group Practice

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To check such pervasive abuses and to assure the fullest possible public disclosure of information, Congress empowered the federal district courts to determine, in suits involving Exemption one of the FOIA, whether the executive branch has complied with its own rules regarding the classification of national security information. Courts inevitably will face difficult and sensitive situations in exercising this new review power. Yet given the mandate of the amended FOIA and the clarity of Congress' intent to insure meaningful judicial review, courts should not lightly interpret the responsibility of the government under the Act. The government is required to sustain the burden of persuasion that its invocation of Exemption one is proper. Courts should carefully avoid procedures or devices that allow the government to evade this statutory responsibility and should require a degree of specificity in the government's arguments sufficient to enable maximum adversary exchange without actually disclosing the contested document. Furthermore, courts should insist on meritorious arguments on the part of the government and not presumptively accept mere pro forma executive assurances that withholding is justified. Only through adherence to these minimum requirements can the courts guarantee that the doctrine of maximum disclosure[123] embodied in the FOIA will not be thwarted.

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MEDICAL CLINICS: LEGAL AND POLITICAL STRUCTURE IN GROUP PRACTICE

INTRODUCTION

Group practice is a rapidly expanding mode for the delivery of health care in the United States[1] and is expected to become the dominant pattern

break-in was imminent, he discussed possible public justifications with his aides, John Dean and H.R. Haldeman. In a tape recorded conversation on March 21, 1973, President Nixon concluded "[o]n that one I think we should simply say this was a national security investigation that was conducted." *Institutional Author*, THE WHITE HOUSE TRANSCRIPTS 163 (New York Times ed. 1974).

123. Justice Stewart has suggested that "the hallmark of a truly effective internal security system would be the maximum possible disclosure, recognizing that secrecy can best be preserved only when credibility is truly maintained." New York Times Co. v. United States, 403 U.S. 713, 729 (1971) (Stewart, J., concurring). This statement is premised on the assumption that "when everything is classified, then nothing is classified, and the system becomes one to be disregarded by the cynical or the careless, and to be manipulated by those intent on self-protection or self-promotion." *Id.* at 729.

1. The total number of medical groups in the United States rose from 404 in 1946 to 1,546 in 1959; 4,239 in 1965; and 6,371 in 1969. U.S. DEP'T F HEW, PUBLIC HEALTH SERVICE, HEALTH RESOURCES STATISTICS 487 (1973) [hereinafter cited as STATISTICS].

of medical practice in the near future.[2] This trend is encouraged by federal and state sponsorship of health maintenance organizations[3] and by the general drift of the health care system toward socialization; group practice is well structured to thrive in the environment of prepaid medical services, national health insurance, and national health planning by the government.

Prior to the recent governmental interest in health care, however, medical practitioners had begun to associate for other, more fundamental reasons.[4] Many doctors believed that the economies of scale, professional discipline, and centralized business management of group practice afforded a better quality of medical care to the public.[5] Furthermore, doctors appreciated the many personal benefits of group practice: regular hours of responsibility, greater tax advantages and fringe benefits, more opportunity for continued education and political activity, added security for referral-dependent specialists, and relief from administrative tasks.[6] It is apparent from the success of older groups and the proliferation of new groups that these expectations have been largely fulfilled. Such results are not surprising, since group practice is a pattern that has long been successful in the legal profession.[7]

The terms "group practice" and "clinic" have spawned considerable confusion. "Group practice," as used herein, refers to a group of doctors

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2. *See* Code, *Determinants of Medical Care—A Plan for the Future*, in NEW HORIZONS IN HEALTH CARE 53 (1970) [hereinafter cited as NEW HORIZONS].

3. *See, e.g.*, 42 U.S.C. §§280c, 300 - 300e-14 (Supp. II 1973); FLA. STAT. §§641.17-.38 (1975). *See generally* Epstein,*HMOs and the Law: How to Avoid Problems With State Statutes*, GROUP PRACTICE, Aug. 1973, at 9; Feldman, *Legislation and Prepayment for Group Practice*, 47 BULL. N.Y. ACAD. MED. 411 (1971); Hoffheimer, *The ABCs of HMOs*, GROUP PRACTICE, Sept.-Oct. 1974, at 25.

4. The leader in the establishment of private group practice is generally acknowledged to be the Mayo Clinic in Rochester, Minnesota. The idea of cooperative group practice pioneered by the Mayo brothers is considered by some doctors to be the most important practical achievement in the delivery of modern medicine. H. CLAPESATTLE, THE DOCTORS MAYO 534, 575-76 (1941) [hereinafter cited as H. CLAPESATTLE]. *See also* W. WIN.LOW, THE MENNINGER STORY 16, 175 (1956).

5. Dr. William Mayo commented: "Properly considered, group medicine is not a financial arrangement, except for minor details, *but a scientific cooperation for the welfare of the sick.* Medicine's place is fixed by its service to mankind; if we doctors fail to measure up to an opportunity it means state medicine, political control, mediocrity, and loss of professional ideals. The members of the medical fraternity must cooperate in this work . . . . The internist, the surgeon, and the specialist must join with the physiologist, the pathologist, and the laboratory workers to form the clinical group, which must also include men learned in the abstract sciences, since physics and biochemistry are leading medicine to greater heights. Union of all these forces will lengthen by many years the span of human life, and as a by-product will do much to improve professional ethics by overcoming some of the evils of competitive medicine." H. CLAPESATTLE, *supra* note 4, at 706 (emphasis original).

6. *See* AMERICAN ASSOCIATION OF MEDICAL CLINICS, AMERICAN MEDICAL ASSOCIATION, & MEDICAL GROUP MANAGEMENT ASSOCIATION, GROUP PRACTICE: GUIDELINES TO JOINING OR FORMING A MEDICAL GROUP 10 (2d ed. 1970) [hereinafter cited as GUIDELINES].

7. "Group practice" in the legal profession is often used to designate prepaid legal service plans, but the analogy here is simply to the large law firm with specialized lawyers and departments.

operating as a private business entity with a common administrative staff, common facilities, and centralized patient records and accounts. The term is sometimes used to indicate prepaid medical care[8] exclusively, but its meaning here will include both prepayment and fee-for-service systems. True group practice should be distinguished from the space-sharing arrangement, often called a "medical arts building." While a number of doctors might be partners or shareholders in a "medical arts building," they usually do not have the merged professional practices characteristic of true groups.[9] "Clinic" will be used interchangeably with "group practice" and will carry no connotation of public subsidy or lower cost. Although groups of one specialty (for example, radiology, anesthesiology) or one purpose (for example, diagnosis) do exist, the typical group of more than seven contains doctors with a wide variety of specialties so that patients can fulfill all their medical needs without going elsewhere.[10]

Planning and forming a medical group requires greater legal skill and care than does the establishment of a typical small business. The clinic must be organized in a recognized legal form that, along with the documents creating it, will determine the basic rights and duties of the group and of its members. For a multispecialty clinic, however, this framework will not provide a sufficient foundation for a stable enterprise. The group must also be given a comprehensive political structure at its inception. Thus, the lawyer's role transcends technical advice on the clinic's formation; he must also advise the group in its four major political areas – choice of entity, management structure, distribution of income, and risk management.[11] While this commentary will consider these internal political areas within the framework of the partnership form of organization, many of the problem-solving techniques can be applied to other forms of organization as well.

Choice of Entity

Comparisons of the business entities available to a group practice typically imply that clinic operations normally fall under the aegis of a single entity.[12] Surveys have found, however, that nearly all established groups operate as clusters of two or more entities related somewhat horizontally as coventurers, rather than vertically as parent and subsidiary.[13] These separate entities are

8. *See generally* Note, *The Role of Prepaid Group Practice in Relieving the Medical Care Crisis*, 84 HARV. L. REV. 887 (1971).

9. See H. CLAPESATTLE, *supra* note 4, at 576.

10. STATISTICS, *supra* note 1, at 489.

11. The recommendation is made in a basic work on group practice that the attorney be engaged on a retainer basis and be thoroughly involved with the clinic's activities to the extent that: "He should be considered one of the group. He should attend quarterly meetings of the clinic and should be invited to all social functions of the organization." Garrett, *Legal and Financial Counsel*, in THE PHYSICIAN AND GROUP PRACTICE 158-59 (E. Jordan ed. 1958) [hereinafter cited as Jordan].

12. *See* NATIONAL ASSOCIATION OF CLINIC MANAGERS, THE CLINIC MANAGER'S MANUAL 3-2 (1958) [hereinafter cited as MANUAL].

13. *See* GUIDELINES, *supra* note 6, at 22; Note, *Group Medical Practice and Clinics: Some Organizational Problems*, 4 STAN. L. REV. 401, 411 (1952).

planned along functional lines – one for the actual practice of medicine, another for the management and ownership of clinic real estate and equipment,[14] and others for ancillary activities[15] such as laboratories, pharmacies, hospitals, research foundations, or prepayment plans. These entity clusters have proven useful in segregating the return on the doctors' capital from their earned income, avoiding conflicts of interest, reducing taxes, and compartmentalizing the management of separate activities. The cluster approach depends heavily on the special circumstances of the group, and since its complications cannot be developed in a general description of the clinic's structure, discussion will be limited to the political framework of the medical practice entity.

The most common forms of organization for the medical practice entity are sole proprietorship, unincorporated association, partnership, and corporation.[16] Sole proprietorship (to be distinguished from solo practice) can rarely survive in a multispecialty clinic.[17] Though multispecialty groups may evolve from sole proprietorships, it is unusual to find a clinic of more than fifteen doctors with one owner.[18] The capital requirements preclude all but the exceptionally wealthy proprietor, and the medical specialists needed to staff such a clinic normally insist on ownership opportunities.

The unincorporated association is a hybrid designed to take advantage of the best elements of partnership and incorporation,[19] particularly with respect to taxes and protection from certain types of liability. Because it is often unclear as to what legal principles apply to an association, its legal predictability is low.[20] Also questionable is whether a form of organization that evolved principally for loosely-organized clubs and societies is appropriate for a cohesive, profit-making business. The appeal of the association is now largely eliminated by the availability of incorporation. The organizational problems of management and control in an association are likely to be the same as in a large partnership.

The major choice of entity for a medical group is the choice between partnership and incorporation. Overwhelmingly, partnership was the pattern of group practice until the late 1960's.[21] Until that time, most states pro-

14. *See* Hirsh, *The Medical Partnership*, 13 DE PAUL L. REV. 28, 32 (1963).

15. *See* MANUAL, *supra* note 12, at 3-32.

16. The foundation has also been used. *Id.* at 3-27. *See also* Eisenberg. *There's a Medical Foundation in Your Future*, MED. ECON., *Sept.* 27, 1971, at 88. This form of organization, however, is not generally used as the primary clinic entity.

17. *See* Jordan, *Sole Proprietorship*, in Jordan, *supra* note 11, at 94.

18. Sole proprietorships accounted for only 4.9% of multispecialty groups of all sizes in 1969. STATISTICS, *supra* note 1, at 493.

19. *See* MANUAL, *supra* note 12, at 3-20.

20. The most controversial topic has been corporate tax treatment, on which a plethora has been written. *See, e.g.*, Maier & Wild, *Taxation of Professional Firms as Corporations*, 44 MARQ. L. REV. 127 (1960); Note, *Qualified Pension Plans for Unincorporated Professional Associations*, 12 STAN. L. REV. 746 (1960); Comment, *Corporate Income Tax Treatment for Professional Groups*, 26 ALBANY L. REV. 246 (1962). The uncertainty of the law is similarly objectionable in the rare use of the Massachusetts business trust as the form of a clinic. *See generally* C. ROHRLICH, ORGANIZING CORPORATE AND OTHER BUSINESS ENTERPRISES §§4.43-.48 (4th ed. 1967).

21. Eighty-five percent of surveyed groups in 1959 were partnerships. U.S. DEP'T OF

hibited incorporation of medical groups on the theory that only natural persons could fulfill the licensing requirements of their medical practice acts.[22] These laws were liberalized by all of the states in a short period,[23] however, and many medical groups rushed to incorporate. The principal reason for the change was the restrictiveness of Keogh retirement plans[24] in comparison to the tax advantages of corporate pension and profit-sharing plans.[25] The Pension Reform Act of 1974[26] has lessened considerably the hypothetical tax advantages of incorporation causing other factors to become correspondingly more important in the choice of an entity.

With the artificial tax incentive of incorporation[27] largely neutralized, the choice of business organization should be made by determining which form is more compatible with the basic nature of the service. The risk of organizing under a form incompatible with that service is that the quality of the service and the reputation of the organization may be injured in subtle ways. When the fundamental differences between self-employment and corporate existence are considered, there emerge several reasons pointing toward partnership as the preferable form of organization for medical groups.

The history of the modern corporation shows that it came into prominence to effect the centralization of capital, labor, and management.[28] Traditionally,

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HEW, PUBLIC HEALTH SERVICE, MEDICAL GROUPS IN THE UNITED STATES, 1959 110 (1963). By 1969 this share had dropped to 68.7%. STATISTICS, *supra* note 1, at 493.

22. *See, e.g.*, People *ex rel.* State Medical Examiners v. Pacific Health Corp., 12 Cal. 2d 156, 82 P.2d 429 (1938); People by Kerner v. United Medical Service, 362 Ill. 442, 200 N.E. 157 (1936); State Electro-Medical Institute v. State, 74 Neb. 40, 103 N.W. 1078 (1905).

23. One of the landmark cases in the area of corporate tax treatment of professional groups was United States v. Kintner, 216 F.2d 418 (9th Cir. 1954), which involved the taxation of a medical clinic. The Treasury regulations that resulted from this case led professionals to lobby vigorously for state statutes sanctioning professional corporations, which would allow such entities to come under the regulation in order to enjoy corporate tax treatment. By December 1971, within ten years from the passage of the first act of this type, all states had enacted such laws. For a summary and comparative tabulation of these statutes, see Eaton, *Professional Corporations and Associations*, 17 BUSINESS ORGANIZATIONS §9.01 (1973). *See also* FLA. STAT. §§621.01-.15 (1975), the first of the statutes to be generally applicable to the several professions employing the "corporation" name; Dunn, *Professional Corporations: Their Development and Present Status With Respect to the Practice of Medicine*, 24 U. FLA. L. REV. 625 (1972).

24. Keogh plans are tax-qualified retirement plans for self-employed persons and their employees established under the Self-Employed Individuals Tax Retirement Act of 1962, 76 Stat. 809 (*codified in* scattered sections of 26 U.S.C.).

25. *See Report of the Committee on Pension and Profit-sharing Trusts*, in ABA SECTION OF REAL PROPERTY, PROBATE & TRUST LAW PROCEEDINGS 135 (1963); Ray, *A Comparison of Tax Benefits Available Under HR-10 With Those Provided by Professional Associations*, 26 GA. S. B.J. 269 (1964).

26. See note 83 *infra*.

27. The House Ways and Means Committee's summary of the bill commented under the heading, "Unjustifiable differences in tax treatment of corporate owner-employees and self-employed individuals under qualified plans": "The fact that pension contributions on behalf of corporate employees are in practice not subject to control has also given rise to claims of discrimination on the part of self-employed persons. Pension contributions made by self-employed persons on their own behalf are limited to 10 percent of earned income up to $2500 a year under present law. These limits also have had the undesirable effect of inducing many individuals, including professional people, who would normally carry

corporate policy is made at the highest levels, those farthest removed from the actual product of the corporation. Health care, however, is not the kind of product that lends itself to centralized judgment and authority; medical policy and ethics are developed and exercised at the primary level of organization — the doctor-patient relationship.

The medical profession is not beyond criticism for its management of the health care system, but the greatest achievements of that system may be largely due to the independence and responsibility enjoyed by the physician in the tradition of self-employment. Although it is true that incorporation of physicians has been motivated primarily by financial incentives,[29] and not a desire to avoid responsibility, and that the attitude of the physician does not deteriorate overnight when his practice is incorporated, the long-run tendency of the employed doctor (even the shareholder-employee) may be to conform to the natural shape of corporate life and to develop an employee mentality in place of a professional posture.[30] Resistence to this trend would take a constant expenditure of personal energy and attention, which experience shows is difficult to sustain.

Although incorporation promises advantages to doctors that the lawyer should consider when advising a group, careful analysis of the group's situation often shows that these benefits are merely theoretical[31] or marginal.[32]

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on their activities as sole proprietors or partners, to convert their activities to the corporate form almost entirely to secure the greater tax advantages associated with corporate plans." H.R. REP. No. 93-779, 93d Cong., 2d Sess. 4 (1974).

28. See R. STEVENS, HANDBOOK ON THE LAW OF PRIVATE CORPORATIONS §1 (2d ed. 1949).

29. "The principle consideration in favor of incorporation for the AAMC members was the corporate tax advantages, particularly deferred income and pension plans. The most frequently cited factors against incorporation were widespread doubts concerning the possibility of future shifts in IRS policy and future legislation, which might reduce the tax advantages of incorporation or increase those of the partnership." Prager & Hunter, *Partnerships or Professional Corporations: A Reappraisal*, GROUP PRACTICE, Jan. 1971, at 16.

30. Dr. M.J. Halberstam has framed this problem in the concept of "personnel," which he defined as "someone whose work obligations are defined by the organization which employs him." Under this view, physicians are not, or should not be, "personnel" because they are defined by oath and peer group outside the organization. A middle group also exists, made up of certain professionals who function at the will of a city department or agency, such as teachers and social workers; these are "professional personnel," whose organizations hold the final responsibility for their practices. Dr. Halberstam comments: "It is obvious from this definition — and from the experience of many of us here — that there are times when the physician himself functions as 'professional personnel.'" Halberstam, *Radical Politics and the Future of Solo Practice*, in NEW HORIZONS, *supra* note 2, at 335 (1970). "These less tangible considerations can be summarized in terms of how well the organizational form, partnership or corporation, fits the concept of group practice as defined by the members of the group . . . . One consideration frequently mentioned by AAMC members in the survey cited was the loss of individual independence and control which some physicians feel is an inevitable result of incorporation." Prager & Hunter, *supra* note 29, at 17.

31. In the process of analyzing the tax treatment of professional corporations, one commentator has written an enlightening, if somewhat antagonistic, appraisal of the "corporateness" of organizations formed under the early enabling statute as it relates to limited liability (professional and business), centralized management, continuity of life, and free transferability of interest. Bittker, *Professional Associations and Federal Income Taxation: Some Questions and Comments*, 17 TAX L. REV. 1 (1961).

The doctors, on consideration of the subjective factors that will affect their practices for decades, may prefer to retain the private, decentralized, professionally oriented partnership format that is so conducive to the practice of medicine.

MANAGEMENT STRUCTURE

Because of the large number of partners in the typical multispecialty clinic, a formal management plan should be written as part of the partnership agreement or as a separate document for the partnership agreement to incorporate by reference.[33] This plan, or reference to it, should also appear in the clinic's standard contract for employed doctors, who are, as a rule, prospective partners serving a probationary period of employed service.

There are two parallel branches of management in clinics — medical practice management and business management.[34] Management of the medical practice, of course, must be the sole responsibility of the doctors, especially the partners. Business administration is largely delegated to lay managers[35] who assume executive responsibility for a wide variety of clinic functions[36] (such as billing, purchasing, personnel, and maintenance). Since partners retain the top management function in business administration, provision should be made in the management plan to subject each area of the business operation to periodic review by some component of the partnership. Overall management responsibility is normally exercised by a governing body or authority augmented by various committees. There are nearly as many different management systems as there are clinics,[37] but the various plans fall into several patterns.

The most basic system is total democracy, whereby all decisions come

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32. To reap the extra advantage of corporate pension plans requires the permanent commitment of large amounts of cash that must be foregone for the purposes of personal consumption or investment in medical facilities. A survey has shown that doctors' preferences for the corporate form are directly proportional to income and that only in the income strata above $80,000 a year do the majority of doctors practice as corporations. Gorlick, *How Much Should You Earn to Make Incorporation Pay?*, MED. ECON., *Feb.* 18, 1974, at 105.

33. *See* Hirsch, *The Medical Partnership*, 13 DE PAUL L. REV. 28, 32-33 (1963).

34. Examination of management plans and charts collected by the Group Practice Information Service of the American Group Practice Association showed that this sharp division of the business function from the professional function is virtually universal, regardless of the form of the organization. *See also* MANUAL, *supra* note 12, at 5-7.

35. The occupation, "clinic manager," has evolved into a new professional category. *Id.*, ch. 1. The National Association of Clinic Managers was founded in 1926 and has been succeeded by the Medical Group Management Association, which had over 800 members in 1969. *See* GUIDELINES, *supra* note 6, at 32-33. High standards of proficiency are stressed and may be rewarded through a testing program leading to Fellowship in the American College of Clinic Managers founded in 1956. *Id.*; *see* MANUAL, *supra* note 12, at 20.

36. *See* H. COTTON, MEDICAL GROUP PRACTICE 65 (1965) [hereinafter cited as H. COTTON]; Heberlein, *The Clinic Manager*, in Jordan, *supra* note 11, at 144-50.

37. Some of the methods used in California groups are listed in Note, *Group Medical Practice and Clinics: Some Organizational Problems*, 4 STAN. L. REV. 401, 407 (1952).

before all of the partners.[38] For a group of more than six or seven partners, the disadvantages of this system are obvious — the difficulty of assembling a meeting, the waste of the doctors' time resulting from the geometric increase in discussion as the number of partners increases, and the desire of some doctors to practice medicine and leave the management of the clinic to those who are interested in such matters.

A good alternative to pure democracy is the functional responsibility approach whereby certain management areas, such as collections or insurance, are the responsibility of particular committees[39] that periodically report results and developments to the group as a whole. These appointments may be semipermanent to allow the doctors to pursue a special interest or to become knowledgeable on some facet of group practice management.

A managing partner,[40] one doctor who assumes overall responsibility, may emerge from the nucleus of a group, but he is likely to serve on an informal basis. As a formal structure, this system has the defect of requiring outstanding leadership qualities from the managing partner, and such an individual may not always be available. A managing partner should be distinguished from a medical director,[41] who holds executive-type authority in the medical practice area similar to the business manager's executive authority in the administrative area.

The dominant management pattern for large groups is the executive committee system,[42] similar in design to the executive committee system for corporate boards of directors. It is necessary, as in the corporate structure, to carefully delineate the powers of the executive committee to clearly indicate when the partners as a whole must be consulted.[43] This system raises some problems regarding the selection of committee members. The interests of each partner must be represented, and this is sometimes achieved by rotating the committee membership. Moreover, it is necessary to consider departmental representation and differences in experience, interest, length of service, and senior or junior partner status. The employed doctors are often represented on the committee, and the business manager may be an *ex officio* member.

The members of a medical partnership share practice quarters, financial rewards, patients, liability, and reputation, so it is of paramount importance that the partnership agreement contain effective disciplinary sanctions against errant colleagues.[44] Several degrees of sanctions are available. Minor measures

38. See H. COTTON, *supra* note 36, at 59.

39. The Mayo Clinic developed such a system of standing committees in the 1920's as a transitional step toward self-government by the staff. Beyond the educational effect of these committees on the doctors, this system had a political effect as well. "When any member got so full of his own and his specialty's importance that he could not see the rights of the other sections in the organization, the board of governors had only to appoint him to some important committee. Dealing there with the problems of the whole group, he soon had a better understanding of the relationship of his own block to the whole structure and was ever afterward more amenable." H. CLAPESATTLE, *supra* note 4, at 703.

40. *See* H. COTTON, *supra* note 36, at 61.

41. *See* Gray, *The Role of the Medical Director*, GROUP PRACTICE, Jan.-Feb. 1975, at 13.

42. *See* Sedgwick, *Leadership and the Executive Board*, in Jordan, *supra* note 11, at 73-75.

43. *Id.* at 75.

44. The liability of the clinic can extend beyond what would normally be considered

include informal chastisement – the private "talking-to,"[45] the official reproach,[46] personal exclusion, and the withholding of privileges.[47] Beyond these informal penalties, discipline in the clinic should be formally prescribed by the agreement. The intermediate penalties are financial: fines, reduction of income shares, reduction of bonuses, loss of points under a point system, or any other method consistent with the group's income distribution system.[48] Financial penalties and expulsion from the partnership usually require a vote of all partners, and it is likely that the doctors forming a group will want to require more than a simple majority approval for such action.[49] For various reasons, some salutary and some self-serving, doctors are loathe to take personal action against other doctors.[50] Therefore, the more assistance the attorney can give the partnership by specifying the grounds for discipline in the agreement, the more effective the disciplinary powers will be. Without this specificity, the group may be psychologically cornered.[51]

INCOME DISTRIBUTION

The most controversial problem in many groups is how to divide the earnings. This subject can lead the group into bitter and time-consuming debate – or even dissolution – if a workable system of distribution is not planned at the outset.[52] The basic objective is allocation of revenue and profits, but the system must also comprehend the related factors of overhead, time off, sabbaticals, vacation, disability, and unpopular duties. The symbolic value of money makes income distribution particularly delicate because

professional or business relations. *See* Maclay v. Kelsey-Seybold Clinic, 456 S.W.2d 229, 232 (Tex. Civ. App. 1970); Comment, *A Duty to Prevent a Copartner From Alienating the Affections of a Patient's Wife is Owed by a Medical Partnership to the Families of its Patients*, 9 HOUSTON L. REV. 152 (1971).

45. "[T]alking-to seems to involve various blends of instruction, friendly persuasion of error, shaming the offender, and threatening him with retaliation." Freidson & Rhea, *Processes of Control in a Company of Equals*, 11 SOCIAL PROBLEMS 119, 125 (1963).

46. *See* H. COTTON, *supra* note 36, at 53-54.

47. Personal exclusion in a clinic means that the offender is not referred patients, is not consulted about problems in his specialty, is not called on to look at interesting cases, and is not included in the system of exchanging favors. The loss of privileges involves rewards such as extra money, serving as a special consultant, supervising a research program, representing the group to distinguished visitors, traveling at clinic expense, or taking leaves of absence. Freidson & Rhea, *supra* note 45, at 127.

48. *See* H. COTTON, *supra* note 36, at 55.

49. *Id.* at 57; Gordon, *The Partnership*, in Jordan, *supra* note 11, at 78-79.

50. *See* Freidson & Rhea, *supra* note 45, at 128-29.

51. "The system is quite helpless in the face of a man who does not depend upon the esteem and trust of his colleagues and who does not respond to the symbolic values of professionalism . . . . Confronted by a man who is not so incompetent or unethical as to be grossly and obviously dismissible, and who fails to show any pride as a professional, the administration and the colleague group are helpless. He cannot be flattered, shamed, or insulted and so cannot be persuaded to mend his ways or resign; all that can be done is to seal him off and try to minimize whatever damage he is believed to do." *Id.* at 129.
at 129.

52. *See* Owens, *Many Partners Are Still Doing It Wrong*, MED. ECON., March 4, 1974, at 129.

the expression of each doctor's contribution or value to the group as an exact dollar figure is unavoidable.[53] It is difficult to compare the earnings of a group doctor to the earnings of a solo practitioner.[54] For example, many fringe benefits and expenses are clinic-paid, and the return on invested capital is usually separated from medical practice earnings through the use of a corporation that owns the assets.[55] Thus, the group approach to medical practice will cause the individual doctor's lifetime income curve to differ from his expected earnings in solo practice, and the lawyer should ensure that the partners are aware of these differences when designing the income distribution plan.

Group doctors can expect two leveling effects on income. Under almost any distribution scheme, the most remunerative specialties subsidize the less remunerative specialties to some degree.[56] This subsidy may be required for the clinic to maintain a full spectrum of specialties,[57] but it is also an indicator of the cooperative spirit of group practice. The second leveling effect is that clinic income plans tend to smooth out the peaks and valleys of an individual doctor's lifetime earnings curve. In group practice, the younger doctors reach full capacity and income very quickly, and the older doctors near retirement are generally protected by the plan from the severe income decline that older solo practitioners often experience.[58] These benefits come at the cost of a lower income peak in midcareer.

The lawyer who negotiates an income distribution plan should draft specific terms (for example, "production," "years of service") ensuring that the plan is predictable, easy to amend,[59] and sufficient for resolving unforeseen happenings. In a medium-sized or large group, a compensation committee is useful for administering the system and for making recommendations to the entire partnership.

An income distribution plan will fall somewhere on the continuum between equal compensation and incentive compensation, usually correlative with the group philosophy toward either cooperation or competition. The simplest distribution plan provides that each partner is to receive a fixed, equal share of the group's distributable income. This system is unappealing to highly motivated individuals and to those who practice highly remunerative specialties, and it is also open to abuse by individual partners. Despite these

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53. *See* Beck, *Dividing the Pie*, GROUP PRACTICE, Sept. 1973, at 9.

54. Aggregate figures do not reflect much difference in earnings. While a 1968 survey showed solo practitioners earning a mean net income in 1967 of $29,771, group practitioners earned a mean net income of $31,000. GUIDELINES, *supra* note 6, at 20. Some of this difference may be accounted for by the concentration of specialists in group practice.

55. *Id.* at 22.

56. *See* Clark, *Forged in Your Own Mold*, GROUP PRACTICE, Sept.-Oct. 1974, at 20.

57. *Id.* at 22. One response to the AAMC survey of income distribution plans specifically provided a subsidy for pediatricians, normally the lowest revenue producers.

58. *Id.* at 20.

59. *Id.* at 21-22. "Most income distribution formulas contrived by physician associates in medical groups have one thing in common: they are seldom permanent. Plans have been altered as many as three or four times in a ten-year period . . . ." GUIDELINES, *supra* note 6, at 22.

shortcomings, it has been used successfully by many groups,[60] presumably to the satisfaction of doctors who desire a very cooperative professional environment.[61]

A fixed share plan may be designed with unequal shares. One suggested plan[62] uses national statistics on the incomes of doctors in the various specialties to determine the expectation of a competent established doctor in each specialty. These norms are then converted into points which reflect the economic prospects of each specialty relative to all others. Adjustments are made for major career factors such as recent entry into the specialty or department directorships. The norms are based on specific data and recomputation every few years can be required by the plan.

At the other end of the continuum is compensation according to individual productivity, which gives greater reward to the competitive and ambitious urges of the doctors.[63] Incentive plans carry the strong appeal of being equitable in the free enterprise tradition; but carried to excess, they defeat some of the cooperative benefits of group practice. When an incentive plan is desired by the group, the lawyer must insist that well-defined terms be included in the partnership agreement or supplementary document. The most basic term is "productivity." A doctor's contribution could be measured by number of patients, number of patient visits, hours worked, charges logged, charges collected, or profits attributable to his efforts. Partners should be advised that results of these indicators may vary considerably, and when a unit of contribution is chosen, it should be clearly defined and explained to foreclose later problems.

Most multispecialty groups merge the principles of equal compensation and incentive compensation into combination income distribution plans.[64] Such combination plans can be implemented with any convenient calculation method once it is decided what factors will be taken into consideration in the overall plan. Point systems are very common methods of calculating income shares. Factors often built in include publication and research, board certification, nonmedical community work, seniority, founder status, education, experience, specialty, service as an officer of a medical society, and many others.

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60. In 1973, 58% of medical partnerships shared income equally. Owens, *supra* note 52, at 130. This figure, however, conceals some important differences among certain types of groups that show up in further breakdowns of the survey data. Only 33% of mixed specialty partnerships shared equally, compared to 66% of the single specialty partnerships. Also, only 35% in the category of partnerships of four or more M.D.'s shared equally, while 74% and 68% of partnerships of two and three M.D.'s, respectively, shared equally. *Id.* at 134-35. The incidence of equal sharing continues to drop as the number of partners increases. *See* note 64 *infra.*

61. *See* Beck, *supra* note 53, at 10.

62. *See* H. COTTON, *supra* note 36, at 46-50.

63. *See* Beck, *supra* note 53, at 11.

64. A survey of the American Group Practice Association (formerly American Association of Medical Clinics), which is composed of relatively large, predominantly multispecialty clinics, indicated that 85.5% used a combination plan, while 7% shared equally and 7.5% based income solely on productivity. Clark, *supra* note 56, at 19-20.

As an income distribution plan becomes more detailed, it also becomes costlier to administer in terms of time, money, and potential antagonism among partners. Though there are many legitimate factors that have a bearing on equitable income distribution, the final results of a complicated formula will probably not differ drastically from those of a simpler version.

It is inevitable that as the income distribution system moves toward the competitive model, the allocation of profits becomes more difficult. Income distribution, however, cannot be isolated from work distribution, which operates inversely — the more competitive the compensation, the easier it is to allocate workloads. The closer the income system is to equal shares, the more difficult are the problems of time off, minimum productivity, and unpopular duties. The lawyer should urge that written policies in the partnership agreement or separate document cover various work distribution areas, including sabbaticals,[65] educational and military leaves of absence, service in political or medical offices, and attendance at meetings.

RISK MANAGEMENT

All the risks associated with property and broad exposure to the public are present in the medical clinic operation. The management of these risks is a continuing responsibility that requires the attention of the executive committee and the business manager. The lawyer also may be closely involved in the evaluation and approval of insurance coverage for these risks. The subject of this section, however, is the category of risks associated with the partnership itself and the individual doctors — professional liability, retirement, disability, and competition from former associates.

Malpractice

For several years, the malpractice insurance market has experienced one crisis after another.[66] Vigorous debates have raged over who is to blame for the deteriorating situation,[67] and legislation has been introduced to bring the problem under control and to prevent the withdrawal of insurers from the market.[68] Volatile supply and high premiums have made this type of

65. For several examples of existing sabbatical policies in clinics, see Altrocchi, *Sabbatical Policy in Group Practice*, GROUP PRACTICE, Aug. 1970, at 19.

66. STAFF OF HOUSE COMM. ON INTERSTATE AND FOREIGN COMMERCE, 94th Cong., 1st Sess., AN OVERVIEW OF MEDICAL MALPRACTICE 1, (Comm. Print 1975) (prepared for the National Conference on Medical Malpractice, co-sponsored by Congressman James F. Hastings and the American Group Practice Association) [hereinafter cited as OVERVIEW]; *see* U.S. DEP'T OF HEW, REPORT OF THE SECRETARY'S COMMISSION ON MEDICAL MALPRACTICE 39 (1973) [hereinafter cited as REPORT].

67. *See, e.g.*, Annas, *Medical Malpractice: Are the Doctors Right?*, 10 TRIAL 59 (1974); Brant, *Medical Malpractice: The Disease and How to Cure It*, 6 VAL. U.L. REV. 152 (1972); Chon, *Practice and Malpractice — The Other Side of the Coin — An Attorney's Viewpoint*, 20 MED. TRIAL TECH. Q. 267 (1974); Demy, *Practice and Malpractice (One Doctor's Viewpoint)*, 1973 MED. TRIAL TECH. ANN. 61; King, *Malpractice Prevention: A Bi-professional Approach*, 1971 INS. L.J. 335; *Medical Report: Malpractice Crisis*, 38 INS. COUNS. J. 521 (1971).

68. For a survey of proposed federal and state legislation on the malpractice problem, see OVERVIEW, *supra* note 66, at 36-183.

insurance a major concern to all doctors.[69] To the extent that private third-party malpractice insurance remains the conventional means of transferring professional liability risk,[70] there are several objectives that the group's lawyer should bear in mind.

The partnership and the individual doctors should be insured by one company, and that same company should carry the clinic's general liability coverage. Gaps between general and professional liability coverages are thus avoided, and coordination of legal strategy is facilitated for malpractice claims involving multiple defendants. Policy limits should be very high; judging from the trend of awards, a five million dollar policy limit on each named insured would not be excessive.[71] High limits are particularly important because of the long discovery periods and time for adjudication of malpractice cases.[72] The policy limits that will apply are those that were in force when the treatment was given, but an award may not be made until several years later. Thus, today's policy limits may have to satisfy judgments well in excess of today's awards.

Self-insurance of the malpractice risk is impractical for all but the largest clinics. The losses involved in malpractice are characteristically low in frequency and high in severity,[73] and it is this type of loss pattern that most requires an insurer for spreading the risk. There is the added danger that the large reserves necessary to fund a self-insurance program will be invested in frozen clinic assets like buildings and equipment and thus not be readily available for the payment of claims.

The discipline and mutual supervision inherent in group practice are two of many reasons that clinics can be regarded as superior professional liability risks.[74] Although actuarial data have not customarily been tabulated to reflect a group-solo distinction, there has been a recent attempt, with favorable

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69. *Id.* at 16, 18; REPORT, *supra* note 66, app., at 494, 541, 552.

70. First-party no-fault coverage for medical injuries has been proposed by some commentators. Havighurst & Tancredi, *"Medical Adversity Insurance"—A No-Fault Approach to Medical Malpractice and Quality Assurance*, 1974 INS. L.J. 69; Keeton, *Compensation for Medical Accidents*, in OVERVIEW, *supra* note 66, at 231. One think-tank, however, has urged retention and improvement of the present malpractice insurance system. Defense Research Institute, *Medical Malpractice Position Paper*, 42 INS. COUNS. J. 66 (1975).

71. "For those specialists subject to high exposure (*e.g.*, anesthesiologists, neuro-surgeons, and orthopedic surgeons), adequate limits are generally considered to be at least $1 million. Those who wish to be covered for virtually every contingency are generally advised to buy limits of $3-5 million." REPORT, *supra* note 66, app., at 548. "The larger companies in the property and liability field can provide coverage of $10 million or more. In cases where the individual underwriter is unwilling or unable to provide coverage beyond a certain limit, the agent of the physician may obtain excess coverage through an additional underwriter." 121 CONG. REC. 1287 (daily ed. March 3, 1975) (medical malpractice background paper by Congressman Hastings).

72. "Settlements are seldom prompt; the average time for cases heard by a jury is 5 years. It takes over 10 years to settle all alleged medical malpractice incidents occurring in any one year." *Id.* at 895 (daily ed. Feb. 19, 1975).

73. *See* REPORT, *supra* note 66, at 10-12.

74. *See* Freidson & Rhea, *supra* note 45, at 123-24; Curran & Moseley, *The Malpractice Experience of Health Maintenance Organizations*, 70 NW. U.L. REV. 69, 84-86 (1975).

results, to isolate the presumably superior experience of group practice within the risk control program of the American Group Practice Association.[75]

A group should be encouraged by counsel to supplement its natural risk control advantages by establishing formal and aggressive machinery in its management structure to reduce the risk of medical misadventure. The formal commitment to high standards of safety and skill may help to attract and hold a malpractice insurance carrier.[76] A committee for this purpose can study and eliminate risks in the clinic routine and act quickly to minimize damages or prevent claims when potential malpractice incidents occur. Such formal structures can also serve as the nuclei of cooperative programs with local bar associations to screen or evaluate alleged incidents of malpractice.[77]

Retirement

In the early days of group practice, provisions for clinics to pay pensions to retired members were difficult to build into partnership agreements without risking severe cash drains on the clinics.[78] The reserving problem was similar to the self-insurance reserving problem encountered in the malpractice area,[79] and retired members had to rely on the group's continued existence for their pensions. The risk of impecunious retirement for self-employed doctors has since been greatly relieved by the tax benefits of the Keogh Act,[80] the availability of incorporation, and the existence of a vigorous pension service industry.

For a period of several years following the wave of enabling legislation for professional corporations, the advantages of corporate pension plans over Keogh plans encouraged many groups to incorporate.[81] This trend affected

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75. "We are implementing a program which in four or five years will give valuable information in regards to claim experience and requirements for reserves and hopefully will reduce premium rates. From this may come some indication that measurably high quality medical practice and a broadly conceived professional liability program can deal fairly with the needs of our patients and relieve physicians of the dread of malpractice threats we are all much aware of currently." Statement of Dr. Joseph B. Davis, Chairman of the American Group Practice Association Insurance Trustees, before the President's Commission on Medical Malpractice, March 24, 1972.

76. *See* REPORT, *supra* note 66, at 63-64.

77. *See* Note, *New Mexico Medico-Legal Malpractice Panel—An Analysis*, 3 N.M. L. REV. 311 (1973); Note, *Medical-Legal Screening Panels as an Alternative Approach to Medical Malpractice Claims*, 13 WM. & MARY L. REV. 695, 704 (1972).

78. *See* Beck, *How To Support Members Who Leave*, GROUP PRACTICE, Jan. 1974, at 8.

79. *See generally* Goshay, *Motivations for Self-Insurance*, in GROUP INSURANCE HANDBOOK 751, 758-59 (R. Eilers & R. Crowe eds. 1965) [hereinafter cited as HANDBOOK].

80. Self-Employed Individuals Tax Retirement Act of 1962, 76 Stat. 809 (*codified in* scattered sections of 26 U.S.C.). The Act allows self-employed persons to deduct certain contributions to "qualified" pension and profit-sharing plans from their income tax. These contributions are not taxable income to the plan participants, and they accumulate tax-free to retirement. Self-employed persons were allowed by the original act to deduct up to the lesser of 10% of their earnings or $2500. "Qualification" of these plans was conditioned upon compliance with rules regarding eligibility, vesting, distributions, discrimination, and integration with Social Security. *Id.*

81. See notes 22-29 *supra*. For a well-balanced account of the incorporation of a 17

even the large groups qualified for especially favorable pension plan provisions under "Super-Keogh" plans that excluded all "owner-employees" (partners having more than a 10% interest in the assets or earnings).[82] The $2500 limitation on tax-free pension contributions to Keogh plans was the most significant disadvantage to self-employed doctors, whose incomes usually justified a much larger retirement benefit than $2500 a year would provide. The Pension Reform Act of 1974,[83] however, raised the ceiling tax deduction for self-employed persons to $7500,[84] which eliminated a large part of the tax incentive for incorporation.[85] The larger corporate pension plan limits provide significant advantage only to those doctors who earn considerably more money than the representative clinic doctor and who are willing to sacrifice a large part of current consumption for greater wealth in old age.[86] There is the further question of whether large shares of personal income should be committed to pension plans. Pension funds are not as freely accessible as savings, and attempts to tap them before retirement may invoke heavy tax penalties outweighing their previous tax benefits.[87]

Retirement programs follow two broad funding patterns that may have intense political implications in medical groups. The "defined benefit" type of plan,[88] widely used in industry, calls for yearly contributions, each calculated to grow at an assumed rate of interest to a fixed sum at retirement. The older the participant, the fewer years the contribution will have to grow at interest and the closer the contribution must be to 100 percent of the ultimate fixed sum. Therefore, it costs more to fund a fixed retirement benefit for an older participant than it costs to fund the same benefit for a younger participant. This system works well in industry, where age correlates somewhat with status and salary level. In clinic partnerships, however, the younger doctor quickly reaches equal status with his older partners, and the drastic imbalance in

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member multispecialty Florida clinic, see *Incorporation: Can You Hack It?*, GROUP PRACTICE, May 1973, at 9.

82. Among other differences, plans covering owner-employees could not delay vesting of employees' contributions, establish a minimum age requirement for participation, or integrate (offset) the contributions with Social Security pension benefits. INT. REV. CODE OF 1954, §§401(d)(2)(a), (3), (6). Plans not covering owner-employees were free to include such provisions, which were also permitted in corporate plans. The superiority of "Super-Keogh" plans has survived the Pension Reform Act of 1974 and has been enhanced in several respects. *See* Moore, *H.R. 10 Plans Under the Pension Reform Law*, 6 TAX ADVISOR 9, 12 (1975). In addition to "Super-Keogh" and "Keogh," the term "mini-Keogh" has been coined to refer to an Individual Retirement Account established by a self-employed person in lieu of a qualified plan covering his employees. Gorlick, *New Pension Legislation*, MED. ECON., Oct. 14, 1974, at 180, 183; *see* INT. REV. CODE OF 1954, §§219, 408.

83. Employee Retirement Income Security Act of 1974, 88 Stat. 829 (*codified in* scattered sections of 26 U.S.C.).

84. INT. REV. CODE OF 1954, §404(e)(1).

85. *See* notes 22-29 *supra*.

86. *See* note 32 *supra*. A single doctor is in the position to choose to forego large amounts of income, but a group of doctors may not be able to agree to a plan committing all of the partners to such a financial policy. *See Incorporation: Can You Hack It?*, GROUP PRACTICE, May 1973, at 10.

87. *See* Moore, *supra* note 82, at 10.

88. INT. REV. CODE OF 1954, §414(j).

pension contributions occasioned by a defined benefit plan is neither politically tolerable nor efficient for tax purposes.[89]

For medical groups, the "defined contribution" type of plan[90] is the better choice. Such programs call for a contribution formula based on earnings. The benefit at retirement consists simply of whatever the accumulated contributions will buy. In addition to ameliorating the age discrimination problem, defined contribution plans are safe from funding inadequacy due to depressed securities markets and are comparatively free of the funding provisions of the Pension Reform Act.[91]

Disability

The disability risk has two dimensions — the effect of disability on the doctor's personal finances and the effect of disability on his partnership interest in the group.

A long-term total disability may have a more catastrophic financial effect on a doctor's family than death,[92] and the amount of money needed to cover the disability risk is often more than the face value of the insured's life insurance. Although disability income (whether from a partnership or from an insurance company) is supposed to replace earnings, often it must be applied to heavy medical expenses of the disabled person, leaving little to actually replace income for normal living expenses.[93]

The lawyer should take an active role in the evaluation of the partners' disability policies and in the selection by the clinic of a group disability insurance program.[94] The definition of disability is the most important element

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89. The ideal situation would be for the pension plan to call for a contribution of exactly $7500 for each partner. If the partners' contributions are drastically unequal, however, a dilemma arises. If an older partner's contribution is $7500 and a younger partner's contribution is $2000, the younger partner loses potential tax benefits. But if the formula is raised to increase the younger partner's contribution and concommitant tax savings, the cost of employees' contributions will increase also and the older partner's contribution over $7500 will be fully taxable.

90. INT. REV. CODE OF 1954, §414 (j).

91. INT. REV. CODE OF 1954, §412. The Act does not exempt the defined contribution pension plans from funding adequacy, but the very nature of this type of plan makes most of the funding section inapplicable. A defined contribution plan (money purchase plan) will be properly funded if the proper annual contribution is made, without regard to the investment performances of prior contributions or changes in actuarial data. *See* P-H PENSION AND PROFIT SHARING, report bull. 6, at 284 (Aug. 16, 1974).

92. Families normally rely on life insurance for protection against loss of the breadwinner, but long-term disability usually does not trigger payment of life insurance face values. An uncompensated long-term disability can cause severe family hardship: loss of income, heavy medical costs, loss of educational opportunity, and disruption of the family's standard of living. The hardship to a single person is much greater. O. DICKERSON, HEALTH INSURANCE 26 (1968).

93. *Id.*

94. *See generally* Smith, *Group Disability Income Benefits*, in HANDBOOK, *supra* note 79, at 373-91.

of such a plan for doctors;[95] coverage not only should protect the occupation of "physician" but also should protect each doctor as a specialist.[96]

The second most important consideration in evaluating the disability insurance program is enforcement of the policy. While reported cases on disability are very favorable to the insured,[97] the more basic problem is that without good enforcement mechanisms short of litigation, individual insureds or clinics may not be in a position to press their policy rights and may be pressured into inadequate settlements.[98] The most favorable enforcement mechanisms are arbitration provisions[99] that afford fair representation of the insured, with minority representation of the insurer, and subscription to association-sponsored plans[100] that exercise mass bargaining power with the group insurers. All of these considerations bear directly on the group's own financial security. For example, if the disabled doctor's policy will not support him in disability, the clinic, as a practical matter, will have to do so. A medical group has a moral obligation to a disabled partner and an image to uphold in the community. No clinic can afford the spectacle of one of its partners suffering financial ruin from disability.

In the instance of total and permanent disability, the group should have an internal policy for retirement of the doctor from the partnership and purchase of his interest. Because of the possibility of rehabilitation, a waiting period can be applied before the retirement takes effect. If a buy-out becomes necessary, however, the partnership faces a liquidity problem since life insurance will not provide protection where the partner does not die. The problem should, therefore, be handled with disability buy-out insurance. The benefits of such a policy can be paid in lump sum or periodic payments to

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95. *See* W. MEYER, LIFE AND HEALTH LAW §§15:2-15:6 (1972, Supp. 1974).

96. *Id.*, §15:4. "If a physician has spent his life as a neuro-surgeon or an opthalmic surgeon he is effectively deprived of his occupation if illness prevents his continuing in that particular field." Dixon v. Pacific Mut. Life Ins. Co., 268 F.2d 812, 815 (2d Cir. 1959).

97. One extraordinarily favorable case was Bowler v. Fidelity & Cas. Co., 53 N.J. 313, 250 A.2d 580 (1969). In addition to several liberal holdings concerning the insured's state of disability under the policy language, the court held that an insurer has a duty of good faith that extends beyond merely not injuring a policyholder's rights. An insurer must affirmatively act to disclose policy rights to the insured where the policy language would be interpreted more restrictively by a layman than the insurer knows it is interpreted by the courts. *Id.* at 328, 250 A.2d at 588 (1969).

98. Disability insurance is designed to pay a stream of benefits to the insured as long as he is disabled (subject to policy limits), and the guarantee that this income will not run out prematurely is one of its most valuable features to the disabled person. Insurance companies, however, actuarially translate this indefinite stream of income into a lump sum based on the average duration of a large number of similar disability claims and set this sum aside as a claim reserve. When a claim is submitted, a company may deny the claim or threaten delays and then offer the insured a compromise lump sum equal to or less than the claim reserve. If the claimant accepts the lump sum settlement, the company has successfully transferred the risk of exhaustible income back to the insured and has cancelled out one of the significant benefits of its product. *See* O. DICKERSON, *supra* note 92, at 630, 697; H. ROSS, SETTLED OUT OF COURT 154-55, 224-29 (1970).

99. *See* J. DONALDSON, CASUALTY CLAIM PRACTICE 171 (1969).

100. *See* J. PICKRELL, GROUP HEALTH INSURANCE 92 (1961); Tookey & Tookey, *Eligibility of Associations*, in HANDBOOK, *supra* note 79, at 609-12.

the clinic for purchase of the partner's interest, and the coverage may be for disability only or for disability and death.[101]

Competition

Without some form of protection from the competition of former colleagues, the group is extremely vulnerable to conversion of its goodwill to the benefit of doctors who may drop out and set up practices in the community in competition with the group.[102] Many doctors join groups directly from training;[103] others have experience but are new and unknown in the community when they join. In either case, the clinic invests a certain amount of its goodwill in the doctor whose practice it sponsors, and the start-up costs of an associate can be formidable. Thus, turnover of newly established associates can be quite expensive to a clinic in terms of patients and money. Damage of a more serious nature can result from the withdrawal and subsequent competition of doctors whose specialties are valuable for referrals or essential to the full-service character of the clinic.

Protection against competition is achieved by including restrictive covenants in partnership agreements and doctors' employment contracts.[104] These covenants typically prohibit any partner or employed doctor who leaves the group from practicing medicine during a specified time period within a certain geographical area, usually a city, county, or area within a given radius of the clinic. Violation of the covenant is normally enforced by injunction, though some groups have attempted to enforce liquidated damages provisions.[105]

Medical partnerships have had a high rate of success in enforcing restrictive covenants by injunction. It is well settled that restrictive covenants that are reasonable as to duration and territory are exceptions to the rule that contracts in restraint of trade are unenforceable as against public policy.[106] The evil of restraint of trade is subordinated to the solemnity of contracts freely entered into by the parties.

Reasonableness generally requires a definite time period and a geographical area roughly corresponding to the range of a medical practice,[107] but in-

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101. See O. DICKERSON, *supra* note 92, at 664-66; *When a Partner Can't Work*, GROUP PRACTICE, May 1972, at 37.

102. *See generally* Caylor, *Restrictive Agreements*, in Jordan, *supra* note 11, at 64.

103. *Id.*

104. *See generally* Dodd, *Contracts Not To Practice Medicine*, 23 BOSTON U.L. REV. 305 (1943).

105. See notes 118, 119 *infra*.

106. See notes 107-120 *infra*; Burdine v. Brooks, 206 Ga. 12, 55 S.E.2d 605 (1949); Foltz v. Struxness, 168 Kan. 714, 215 P.2d 133 (1950); Lovelace Clinic v. Murphy, 76 N.M. 645, 417 P.2d 450 (1966); McCallum v. Asbury, 238 Ore. 257, 393 P.2d 774 (1964). *See also* FLA. STAT. §542.12 (1975).

107. *See, e.g.*, Raiford v. Kramer, 231 Ga. 757, 204 S.E.2d 171 (1974) (5 county area/2 years); McMurray v. Bateman, 221 Ga. 240, 144 S.E.2d 345 (1965) (50 mile radius/3 years); Bauer v. Sawyer, 8 Ill. 2d 351, 134 N.E.2d 329 (1956) (city/5 years).

definite time periods[108] and areas as large as 100 miles in radius[109] have been upheld. In judging the reasonableness of a covenant's terms, the courts have refused to credit allegations that the protection of the clinic is unneeded,[110] that the competing doctor would be subject to unconscionable hardship under the covenant's terms,[111] or that the covenant was entered into under duress.[112] Findings of unreasonableness are rare.[113]

Proof of damages may be required by some courts,[114] but the stronger position appears to be that no specific damages need be shown in an action for injunctive relief.[115] Enforcement of the covenant may be carried out selectively by the group, and a tradition of nonenforcement does not constitute a waiver of the group's rights under the covenant.[116] It is also possible for a sole remaining partner to enforce the covenant, even though the partnership ceases to exist when the last two partners disassociate.[117] Instead of an outright prohibition of competing practice, the payment of a specific sum, forfeiture of accounts receivable, or forfeiture of buy-out payments are required by some clinics' restrictive covenants.[118] These liquidated damages provisions are coupled with criteria for reasonable duration and territory but are not as favorably received by the courts as those simply prohibiting competition.[119]

The remaining partners have an interesting tactical advantage in their enforcement of a restrictive covenant. The doctor hoping to defeat the covenant after a long association with the clinic may be barred by the statute of limitations from an action for declaratory judgment to have the agreement declared void because, for that purpose, the statute runs from the signing of the agreement.[120] The clinic's cause of action, however, is for breach of the agreement, and the statute does not begin to run until the alleged breach occurs. Thus, in such circumstances, the doctor cannot be sure of

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108. Storer v. Brock, 351 Ill. 643, 184 N.E. 868 (1933) (city of Chicago); Foster v. White, 248 App. Div. 541, 290 N.Y.S. 394 (1936) (county). *But see* Rakestraw v. Lanier, 104 Ga. 188, 30 S.E. 735 (1898) (15 miles).

109. Beam v. Rutledge, 217 N.C. 670, 9 S.E.2d 476 (1940) (5 years); Harrington v. Hackler, 181 Okla. 396, 74 P.2d 388 (1937) (5 years; agreement upheld but area modified from 100 miles to within county).

110. Cogley Clinic v. Martini, 253 Iowa 541, 112 N.W.2d 678 (1962).

111. *Id. See also* Canfield v. Spear, 44 Ill. 2d 49, 254 N.E.2d 433 (1969).

112. Lareau v. O'Nan, 355 S.W.2d 679 (Ky. Ct. App. 1962); Foster v. White, 248 App. Div. 541, 290 N.Y.S. 394 (1936).

113. *See, e.g.*, Rakestraw v. Lanier, 104 Ga. 188, 30 S.E. 735 (1898); Droba v. Berry, 73 Abs. 603, 2 Ohio Op. 2d 50, 139 N.E.2d 124 (Ct. Com. Pl. 1955).

114. *See, e.g.*, Willman v. Beheler, 499 S.W.2d 770 (Mo. 1973); Melrose v. Low, 80 Utah 356, 15 P.2d 319 (1932).

115. *See, e.g.*, Canfield v. Spear, 44 Ill. 2d 49, 254 N.E.2d 433 (1969); Cogley Clinic v. Martini, 253 Iowa 541, 112 N.W.2d 678 (1962); Lareau v. O'Nan, 355 S.W.2d 679 (Ky. Ct. App. 1962).

116. Thompson v. Allain, 377 S.W.2d 465 (Mo. Ct. App. 1964).

117. Ashley v. Lance, 75 Wash. 2d 471. 541 P.2d 916 (1969); Thickman v. Schunk, 410 P.2d 987 (Wyo. 1966).

118. This device is recommended in H. COTTON, *supra* note 36, at 88-89, 91.

119. *See* Bauer v. Sawyer, 8 Ill. 2d 351, 134 N.E.2d 329 (1956); Melrose v. Low, 80 Utah 356, 15 P.2d 319 (1932).

120. Taylor v. Lovelace Clinic, 78 N.M. 460, 432 P.2d 816 (1967).

his legal position until he has set up his new practice and has been sued by the clinic. This risk may be sufficient to deter members' defiance of the covenant.

Although there are practical reasons for the use of restrictive covenants, there are factors militating against their use. These agreements are clearly restraints of trade and have received the support of the courts only because of the great weight that the courts feel they must give to freedom of contract. Otherwise, the detriment caused to the doctor, his patients, and the community would surely override the interests of the clinic, which usually cannot show serious damage. The controversy and litigation growing out of a restrictive covenant can also be harmful to the group from the standpoint of public relations.[121] It has been suggested that the enforcement of restrictive covenants is at odds with the philosophy of group practice.[122]

CONCLUSION

The medical partnership is a business, but most medical partners are more devoted to their professional pursuits than they are to the business aspects of medical practice. Indeed, one prominent group doctor has expressed the view that idealistic motives are essential to a group's survival.

> [In other words,] *the organization which considers the welfare of the patient paramount and makes everything else subservient to this goal, is the organization which is likely to succeed, whereas the organization which is interested primarily in monetary gain usually fails.*[123]

Group doctors are best able to exercise their professional dedication to the benefit of their patients when the clinic operates under a system that does not make unreasonable demands on their time and attention. For purposes of organizational design, the clinic is a legal and political system for which the lawyer is the constitutional draftsman. Conscientious planning of the medical partnership should result in professional satisfaction to the lawyer, peace of mind to the doctors, and improved health care to the public.

GEORGE REARDON

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121. Caylor, *Restrictive Agreements*, in Jordan, *supra* note 11, at 65-66. In one reported case, the local medical society passed a resolution, which was offered into evidence, condemning the clinic's action. Hefelfinger v. David, 305 So. 2d 823 (1st D.C.A. Fla. 1975).

122. "We countered (the proposal for a restrictive covenant) with the fact that if we feared such a possibility, then the premise of the group practice was not valid. If we could not give better service as a group than an individual could alone, the philosophy of group practice was not sound. We have had a few members of the staff who have left and, indeed, some of them have taken an occasional patient with them. They have always left, however, with our blessing and because they were unable to work as a part of a team." Ochsner, *The Need for Teamwork in Medical Care*, in NEW HORIZONS, *supra* note 2, at 70.

123. *Id.* at 71 (emphasis original).