9

How Power Undermined the Medical Profession

Allison K. Hoffman

Mere decades ago, ambitious college students who wanted a lucrative career dreamed of being doctors. Today, they imagine a future as venture capitalists. Over the course of the twentieth century, the medical profession in the United States aggrandized power and profit and is now watching it begin to slip away.[1] Although there is no single explanation for this meteoric rise and gradual decline, this chapter argues that one factor has been the profession's own success. As medical science advanced, it afforded doctors increasing authority and, acting through professional associations, they used this authority to shape the law to protect their turf and their profits. And it also, I argue, had a terrible side effect. Because buried within the rise of professional autonomy and power was also the profession's sharp decline – a decline that may hold important lessons for reformists focused on building a new era of the legal profession.

In medicine, the twentieth century ushered in scientific advances and the beginning of modern medicine and, with it, the growth of a powerful profession.[2] As Paul Starr described in his classic 1982 tome, "the profession has been able to turn its authority into social privilege, economic power, and political power. In the distribution of rewards from medicine, the medical profession, as the highest-paid occupation in our society, receives a radically disproportionate share."[3]

Led by associations, most prominently the American Medical Association (AMA), doctors worked assiduously throughout the twentieth century to concentrate their power and to maximize professional sovereignty. And it worked. Doctors wrested control over both state and federal laws and policies regulating the delivery of medicine.[4] They suppressed efforts to impose market competition in health care,

[1] Mind you, medicine remains a lucrative profession for the meantime, certainly more so on average than law.

[2] Paul Starr, The Social Transformation of Medicine (1982).

[3] *Id.* at 5.

[4] Timothy S. Jost, *Introduction*, *in* Regulation of the Healthcare Professions 2–3 (Timothy S. Jost ed., 1997).

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which threatened to displace physician authority with consumer authority.[5] And they used their power to bend payment policies in their favor.

This aggregation of power enabled doctors to control supply, influence prices, and limit their exposure to critique and liability. And it built enduring structures that served to reproduce authority through legislative and market pressure.[6] It came, at times, at the expense of patients and taxpayers, as health care costs skyrocketed. It also produced less than ideal patient and physician experiences, including the seven-minute doctor's office visit that we've all experienced, a period too short to diagnose or to manage any complex health situation.

Physicians have commanded high prices and profits. The startling irony is that the profits that physicians worked so hard to generate, accumulate, and protect have now lured in outside investors – corporate health systems, insurers, and, most recently, private equity companies – looking to extract these profits.

Early evidence suggests that this corporatization has not markedly increased access to medical care, maybe diminishing quality, and has undoubtedly changed the patient experience and the nature of the medical profession. Doctors are beginning to look like one small input into a larger medical economy, and patient care has become often impersonal. Medical doctors now operate in ways unrecognizable to doctors of a generation prior. After a century of resisting external control, they rarely run their own shops, or, increasingly, even group practices. They are more often beholden to large corporate entities. Medicine still enjoys some benefits of professionalism: high pay, respect, and job security. Yet, the practice of medicine is undoubtedly in decline, measured not only by decreasing autonomy but also by decreasing satisfaction and respect.[7]

Focused on efficiency more than professionalism, the new health care economy will come to value workers who can perform tasks at lower labor costs, thereby eroding the turf and earnings that doctors worked so assiduously to defend. Advanced practice nurses, pharmacists, and others are no longer mere "physician extenders." They are increasingly central players. Yet, all these providers have become corporatized and commodified, as the most astute observers like Paul Starr and Tim Jost predicted four decades ago at the nascence of the decline of the profession.[8]

This chapter engages in a thought experiment. It asks: If doctors had pursued a different strategy, could they have retained the profits they worked so hard to earn – and would this alternative system have been better, both for physicians and their

[5] See, for example, id. at 3; Clark C. Havighurst, Deregulating the Health Care Industry: Planning for Competition 89 (1982) (discussing how self-regulation by the medical profession contributed to anticompetitive conditions in health care).

[6] Starr, *supra* note 2, at 19.

[7] For the beginnings of this decline, *see id.* at 391. *See also* Eyal Press, *Standard of Care*, N.Y. Times Mag. (June 18, 2023).

[8] Starr, *supra* note 2, at 428, 444–49; Jost, *supra* note 4, at 4–5.

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patients? This question is important in its own right and also because this inquiry holds crucial lessons for medicine's sister profession: law. In some ways, law and medicine (or access to justice and access to care), although often analogized, may not be similar enough to compare. But some larger themes and questions might transcend these differences. This chapter considers why law has not gone the way of medicine and whether medicine's trajectory might offer law a cautionary tale. Does gatekeeping help or hinder a profession? How might resistance of government funding and of corporate ownership be a preservation strategy and what does that mean for nascent efforts to allow corporate investors in law firms? And what does the nature of the profession mean, at the end of the day, for the people it serves?

This chapter couldn't possibly answer all these questions. By asking them, however, it probes the importance of the link between the character of the profession and access to quality services, and it illuminates how understanding medicine might deepen, enrich, and complicate conversations about law reform.

9.1 THE PROFESSION'S CONTROL OVER THE REGULATION AND BOUNDARIES OF THE PROFESSION

9.1.1 *The Rise of Associations and the Self-Regulation of Medicine*

The very idea of what the medical profession is and who it includes was largely constructed by professional associations through efforts to shape regulation of the practice of medicine. The AMA, chief among medical professional associations for many decades, was founded in the 1840s when the profession was wholly unregulated.[9] The next decades brought increased reliance on doctors, who became more capable at helping patients.[10] A profession formed that, using legal tools, defined its own boundaries, sought self-protection, and set its own obligations and standards.

Physicians, represented by the AMA starting in the mid-nineteenth century and joined over the course of the twentieth century by specialty associations, led efforts to shape the face of medical regulation. Framed as necessary to protect patients and ensure good care, these efforts served also to insulate the profession from competition.[11] Four primary efforts ultimately sought to bolster and protect physicians and their earnings. The first three – licensure laws, scope-of-practice restrictions, and medical education pipeline control – suppressed the size of the profession and reserved certain domains of practice only for physicians. The final one,

[9] Starr, *supra* note 2, at 18.

[10] *Id.* at 18, 145.

[11] *But see* Gabriel Scheffler & Ryan Nunn, *Occupational Licensing and the Limits of Public Choice Theory*, 4 Admin. L. Rev. Accord 25, 33–34 (2019) (arguing that the public choice account of licensure may be overstated, that early licensure laws were at least in part motivated by driving out unqualified practitioners, and that they improved quality).

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corporate practice of medicine laws, attempted to limit nonphysician interference with medical practice. They all have close corollaries in law.

9.1.1.1 Licensure and the Unlicensed Practice of Medicine

First, physicians sought to limit who could practice medicine with strict licensure requirements. Modern licensure laws, which emerged in the nineteenth century, are codified in state practice acts and require graduation from accredited schools and passage of examination to practice.[12] Practitioners argued that these laws would protect the public from quackery, and they did to some degree,[13] but licensure laws also became a tool to police the bounds of the profession, tamping down supply.[14]

Licensure laws were developed state-by-state, based on state police powers, and their broad wording meant that many activities might constitute "medical practice," which was reserved for physicians. In these laws' current form, the term "medical practice" continues to encompass wide swaths of activities: One author describes these laws as constructing a "practically limitless range of activity within the exclusive power of medicine," possibly even reaching mundane activities like ear piercing or blogging.[15] Bill Sage and Linda Aiken describe medicine as "noteworthy among modern professions for having staked out far more territory than physicians themselves can service, and for managing that territory by delegating duties to other professions who remain subject to physician control and supervision."[16] This delegation structure later began to crumble, as discussed below.

Despite being passed in the name of high-quality care, licensure laws are rarely invoked to police poor-quality care.[17] They have, however, been used to discipline complementary or alternative medical practitioners as engaged in the illegal practice of medicine, a violation that is punishable criminally.[18] New private and public structures developed in the 1980s–90s to attempt to regulate quality more directly. Some identified this moment in time as the beginning of bureaucratic control over, or the proletarianization, of practice.[19]

[12] Timothy Stoltzfus Jost, *Oversight of the Quality of Medical Care: Regulation, Management, or the Market?*, 37 Ariz. L. Rev. 825, 828 (1995).
[13] Scheffler & Nunn, *supra* note 11, at 34.
[14] Jost, *supra* note 12, at 829.
[15] Sandra Johnson, *Structure of Governmental Oversight of Quality in Healthcare*, *in* The Oxford Handbook of U.S. Health Law 503 (I. Glenn Cohen et al. eds., 2016).
[16] William M. Sage & Linda H. Aiken, *Regulating Interdisciplinary Practice*, *in* Regulation of the Healthcare Professions 74 (Timothy S. Jost ed., 1997).
[17] Nadia Sawicki, *Character Competence, and the Principles of Medical Discipline*, 13 J. Health Care L. & Pol'y 285 (2010).
[18] Johnson, *supra* note 15, at 500, 504. Some states allow complementary or alternative practices in "Health Freedom Acts," or by licensing them separately. *Id.* at 504.
[19] Jost, *supra* note 12, at 829, n.73.

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9.1.1.2 Depressing Supply through Medical Education

The medical profession also constrained the supply of physicians by limiting its own pipeline.[20] Toward the end of the nineteenth century, medicine was a growth industry; the number of medical schools was on the rise and women were entering medicine in increasing numbers, including through training in elite institutions where they were welcomed because they brought much-needed financial contributions.[21] In 1904, however, the AMA halted this expansion with the creation of a Council on Medical Education that began grading institutions and, in 1906, fully approved only half of the 160 medical schools in existence.[22] State licensure boards adopted the heightened requirements espoused by the AMA, including moving from a two- to a four-year course of study, pushing many medical schools out of business.[23]

This standardization already underway was hastened by the 1910 Flexner Report, written for the Carnegie Foundation by Abraham Flexner, a doctor trained at Johns Hopkins University in what he characterized as the ideal of experimental science-based education.[24] He criticized the overproduction of medical schools as "private ventures, money making in sprit and object" and "wholly didactic," instead of institutions focused on training doctors clinically.[25] He made the case that a prior college degree in fundamental sciences and language should be a prerequisite for medical education, which, itself, should be based on doing, not watching.[26]

In the following decades, more than half of medical schools merged or closed, including five of seven historically Black medical schools (Howard University College of Medicine and Meharry Medical College remained).[27] Medical schools limited admissions for women, and alternative medicine was sidelined or extinguished.[28] This decline in medical training depressed medical care, exacerbating shortages in rural areas and poor areas.[29]

Following this initial narrowing of admission came a second one with the creation of specialties, starting with ophthalmology in 1916.[30] A system of self-

[20] *Id.* at 830.
[21] Starr, *supra* note 2, at 117.
[22] *Id.* at 118.
[23] *Id.*
[24] Abraham Flexner, Medical Education in the United States and Canada: A Report to the Carnegie Foundation for the Advancement of Teaching (1910); *see* Starr, *supra* note 2, at 188.
[25] Flexner, *supra* note 24, at 3–6.
[26] *Id.* at 53, 90, 125.
[27] Louis W. Sullivan & Ilana Suez Mittman, *The State of Diversity in the Health Professions a Century after Flexner*, 85 Acad. Med. 246 (2010).
[28] Starr, *supra* note 2, at 124; Frank W. Stahnisch & Marja Verhoef, *The Flexner Report of 1910 and its Impact on Complementary and Alternative Medicine and Psychiatry in North America in the 20th Century*, Evid.-Based Complementary & Alt. Med. (2012).
[29] Starr, *supra* note 2, at 125.
[30] Jost, *supra* note 12, at 830.

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regulatory specialty boards was developed to exercise control over various specialties, and the Advisory Board for Medical Specialties was formed in 1933.[31] The division of the profession into specialties created more particularized claims to expertise and, in turn, enhanced payment. Today, and traceable to efforts by the AMA, doctor shortages persist at critical levels, especially in primary care where compensation lags behind most specialties.

9.1.1.3 Scope of Practice

After shrinking the pool of doctors, physicians preserved maximal authority by limiting the care nonphysician health care professionals could provide. Scope-of-practice laws, which both license and constrain practice, dictated who could do what among nurses, nurse practitioners, naturopathic doctors, acupuncturists, nurse midwives, and others. For example, when nurse practitioner training began, these laws determined whether nurse practitioners could diagnose conditions, prescribe medication (including controlled substances), and treat chronic conditions independent of physician supervision[32] and also set the structure of physician supervision required.[33] The providers regulated by scope-of-practice laws were even called "physician extenders," a term that emphasized their role, as secondary to physicians.[34] These laws have become controversial as evidence mounts that lifting these restrictions increases access to care without compromising quality,[35] but the AMA continues to resist their liberalization.[36]

9.1.1.4 Corporate Practice of Medicine Restrictions

A fourth and final way that physicians tried, but ultimately failed, to retain maximal control was through state prohibitions against the "corporate practice" of medicine.

[31] *Id.*

[32] *State Practice Environment*, Am. Ass'n Nurse Practitioners (updated Oct. 2024), https://www.aanp.org/advocacy/state/state-practice-environment (last accessed Mar. 12, 2023).

[33] *Id. See also* Chapter 8 in this volume.

[34] These laws are criticized as anticompetitive. Fed. Trade Comm'n, Policy Perspectives: Competition and the Regulation of Advanced Practice Nurses 20 (2014); E. Kathleen Adams & Sara Markowitz, *Improving Efficiency in the Health-Care System: Removing Anticompetitive Barriers for Advanced Practice Registered Nurses and Physician Assistants*, The Hamilton Project (June 2018).

[35] *See, for example*, Mary O. Mundinger et al., *Primary Care Outcomes in Patients Treated by Nurse Practitioners or Physicians: A Randomized Trial*, 283 JAMA 59 (Jan. 5, 2000) (showing that random assignment to a primary care nurse practitioner or doctor produced similar outcomes); Sara Markowitz et al., *Competitive Effects of Scope of Practice Restrictions: Public Health or Public Harm?*, 55 J. Health Econ. 201 (2017) (showing that practice restrictions on nurse midwives increase rates of induced labor and Cesarean section birth with no effect on health outcomes).

[36] *AMA Successfully Fights Scope of Practice Expansions that Threaten Patient Safety*, Am. Med. Ass'n (May 15, 2023), https://www.ama-assn.org/practice-management/scope-practice/ama-successfully-fights-scope-practice-expansions-threaten (last accessed Feb. 18, 2025).

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Some feared that when those acting in the service of patients were controlled externally, it could infuse profitmaking into their consciousness and tarnish the profession. Common laws and statutes in most states thus restricted business and managerial control over medical practice. But as medicine began to look more like a business than a calling over the latter half of the twentieth century, corporate practice of medicine laws were circumvented, repealed, overturned, limited, or unenforced.

9.2 THE MEDICAL PROFESSION'S CONTROL OVER PRICES

The emergence of modern health care financing, including the 1965 passage of Medicare and Medicaid and the growth of managed care beginning in the 1970s, threatened the imposition of external controls over medical practice. In the 1970s–80s, health care prices soared, and questions over health care quality provoked a movement toward quality management and improvement.

Having public and private insurers as powerful intermediaries could, in theory, have swiftly tempered professional influence. To the contrary, the introduction of external financing brought an infusion of spending that increased the stakes of payment policy, and the profession's use of its political capital to shape this policy intensified. This section traces how the profession used its influence to shape insurance into a tool for profitmaking.

9.2.1 *Medicare Fuels the Profession*

The early to mid-twentieth century brought debates over the government's role in financing health care, and the AMA resisted government-financed health care because of the fear that it would bring regulation along with the financing. Although the AMA contributed to the defeat of national health insurance, Medicare passed in 1965 over AMA resistance.[37]

Yet, instead of Medicare bringing professional regulation, the profession has since shaped the program for its benefit. Medicare has created a steady and reliable funding stream for inpatient and outpatient care. The Medicare Act provided that outpatient care would be compensated at rates that were "reasonable" or "customary," terms that became defined based on the amounts that doctors billed for care.[38] This squishy statutory language fanned the flames of medical inflation through the 1970s, and as doctors' billed amounts increased, Medicare's price tag ballooned.[39]

[37] Theodore R. Marmor, THE POLITICS OF MEDICARE 77 (2nd ed. 2000).

[38] *Medicare Coverage Determination Process*, CTRS. FOR MEDICARE & MEDICAID SERVS. (last modified Sept. 10, 2024), https://www.cms.gov/Medicare/Coverage/DeterminationProcess (last accessed Apr. 25, 2023).

[39] Marmor, *supra* note 37, at 89.

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The Medicare Act also delivered an explicit promise not to interfere with the profession. In its very first section, the statute provides:

> Nothing in this subchapter shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person.[40]

Although Medicare has undoubtedly deeply shaped health care delivery, this provision has cabined payment and quality reform. As just one example, the Affordable Care Act (ACA) created a body to study comparative cost effectiveness to pay more for higher-value care.[41] Although this Patient-Centered Outcomes Research Institute (PCORI) was formed, it was prohibited from considering the relative cost of treatments; rather it was only allowed to consider the effectiveness of treatments.[42] This means that if two treatments are both effective but they vary wildly in price, their relative prices are not allowed to factor into PCORI-funded analysis.[43]

Physicians also directly influence reimbursement rates in various ways. For example, in 1992 Medicare transitioned to paying doctors based on a relative scale of how much effort goes into different categories of care.[44] Medicare sets the amount paid for a base unit, and a committee of the AMA called the RVS Update Committee (RUC) determines the multiplier for each type of encounter. The AMA Board of Trustees selects the RUC chair, and specialty societies nominate individual members. Of thirty-two current members, over two-thirds represent specialties, and in 2023 only four were women (practicing in pediatrics, geriatrics, osteopathy, and primary care).[45] This means that regulators defer to doctors – and a skewed sample of doctors, at that – to determine how much Medicare pays for a therapy session versus a surgeon's fee for a knee replacement versus a pediatric well visit.

Primary care doctors, whose work is relatively undervalued through this process, have also accreted power through policies including so-called value-based models of care. The ACA created a Center for Medicare & Medicaid Innovation

[40] Pub. L. No. 89–97, tit. I, §102(a), 79 Stat. 291 (1965).

[41] Alan M. Garber & Harold C. Sox, *The Role of Costs in Comparative Effectiveness Research*, 29 Health Affs. 1805, 1806 (2010).

[42] *Id.* at 1806.

[43] *Id.* at 1806–07; *What Is PCORI's Official Policy on Cost and Cost-Effectiveness Analysis?*, PCORI (last updated Sept. 1, 2023), https://www.pcori.org/funding-opportunities/applicant-and-awardee-resources/frequently-asked-questions/collecting-data-costs-and-economic-burdens-faqs (last accessed Feb. 24, 2025) (last accessed Apr. 25, 2023).

[44] Marmor, *supra* note 37, at 113.

[45] *Composition of the RVS Update Committee (RUC)*, Am. Med. Ass'n, https://www.ama-assn.org/about/rvs-update-committee-ruc/composition-rvs-update-committee-ruc (last accessed Mar. 9, 2023).

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(CMMI, now called the CMS Innovation Center) within CMS to test new payment models,[46] which pay bonuses when patients achieve health outcomes within spending parameters. Primary care doctors are the lynchpin to success and profit in these models. This fact has drawn the attention of corporate investors in primary care. Over the past decade, corporate investors have begun to aggregate primary care doctors into formal or informal networks. These typically private-equity-backed entities (e.g., Oak Street Health, ChenMed, and One Medical) have, in turn, begun to change the nature of primary care practice, as discussed below.

9.2.2 *Consolidation and Power over Private Insurers*

The story of private insurance was much the same (until recently): Despite insurer efforts to manage cost inflation, the profession gained the upper hand by consolidating to preserve and enhance their rates. Initially, private fee-for-service insurance did not restrict the providers or medical care someone could use.[47] During the 1980s–90s, managed care gained steam as an attempt at cost control. Insurance companies created limited networks and began to push back on prices with credible threats that they would exclude providers from their networks if their prices were too high.[48]

That period was short lived. Patients protested overly restrictive networks. Hospitals and doctors consolidated in ways that aggrandized their own power vis-à-vis insurers. Even when the Federal Trade Commission (FTC) attempted to slow provider consolidation, courts backed doctors and hospitals in their resistance of managed care.[49] The end result has been high prices and insurers and employers who are price takers, unable to negotiate down rates. Even large employers increasingly express frustration at their inability to control prices in employee health plans.[50]

That said, the tides may be turning, as insurers like UnitedHealth Group have over the past decade sought to regain the upper hand by acquiring physician practices and steering patients toward doctors who are under their control.[51]

[46] *About the CMS Innovation Center*, Ctrs. for Medicare & Medicaid Servs. (updated Aug. 14, 2023), https://innovation.cms.gov/about (last accessed Apr. 25, 2023).

[47] Jon Gabel et al., *Withering on the Vine: The Decline of Indemnity Health Insurance*, 19 Health Affs. 152 (2000).

[48] *Id.*

[49] *See, for example*, FTC v. Tenet, 186 F.3d 1045 (8th Cir. 1999) (rejecting the FTC's antitrust challenge to a merger between two hospitals).

[50] Kaiser Family Found. & Purchaser Bus. Grp. on Health, *How Corporate Executives View Rising Health Care Costs and the Role of Government* 5–6 (2021), https://www.pbgh.org/wp-content/uploads/2021/04/9704-How-Corporate-Executives-View-Rising-Health-Care-Costs-and-the-Role-of-Government-v2.pdf (last accessed Feb. 18, 2025).

[51] Reed Abelson, *UnitedHealth Buys Large Doctors Group as Lines Blur in Health Care*, N.Y. Times (Dec. 6, 2017); John Tozzi, *UnitedHealth Chases 10,000 More Doctors for Biggest U.S. Network*, Bloomberg (Mar. 5, 2021), https://www.bloomberg.com/news/articles/2021-03-05/uni

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This trend is beginning to shift the power dynamic between insurers and doctors, as discussed below.

9.3 WHAT A CENTURY OF AGGREGATION OF REGULATORY AND MARKET POWER PRODUCES

For a century, doctors worked on turf building and defending until they became one of the most valuable pawns in the game of health care, second perhaps only to patented drugs and medical devices in an industry that constitutes nearly one-fifth of the economy. Yet, what these efforts have produced for practicing physicians is far from what was initially envisioned. Even worse, at the macro level, it may be contributing to the erosion of high-quality and humanely delivered medical care.

9.3.1 *Modern Professional Threats: Employment and Investment*

9.3.1.1 Physician Employment

Physician employment has accelerated dramatically, and the form and nature of employment have become complex. Initially, doctors were either in private practice or employed by hospital systems, but practices are now owned in various forms by physicians, hospitals, and/or corporations, and corporate ownership includes insurers, private equity firms, and others.[52] By one conservative count, over half of doctors are now employees, rather than owners of their own practice, including 66 percent of doctors under age forty and nearly 60 percent in fields including family medicine and pediatrics that used to be the hallmarks of independent physician practice.[53] Another study estimated that three-quarters of physicians were employed in 2022, up from just over 60 percent three years prior.[54] Even in surgical subspecialties, which have long resisted this trend, over one-third of doctors are now employees.[55] The COVID-19 pandemic accelerated this trend.[56]

tedhealth-s-deal-machine-scoops-up-covid-hit-doctor-groups#xj4y7vzkg (last accessed Feb. 18, 2025).

[52] Eliza Daily, *Physician Employment Is Changing. What Does that Mean for the Industry?*, Advisory Board (Apr. 26, 2022), https://www.advisory.com/daily-briefing/2022/04/27/physician-employment (last accessed Feb. 18, 2025).

[53] Carol K. Kane, *Policy Research Perspectives, Recent Changes in Physician Practice Arrangements: Private Practice Dropped to Less than 50 Percent of Physicians in 2020* 12–13, Am. Med. Ass'n (2021), https://www.ama-assn.org/system/files/2021-05/2020-prp-physician-practice-arrangements.pdf (last accessed Feb. 18, 2025).

[54] Avalere Health, *COVID-19's Impact on Acquisitions of Physician Practices and Physician Employment 2019–2021* 11–13 (2022), http://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/PAI-Research/PAI%20Avalere%20Physician%20Employment%20Trends%20Study%202019-21%20Final.pdf (last accessed Feb. 18, 2025).

[55] Kane, *supra* note 53, at 13.

[56] Avalere Health, *supra* note 54, at 14–16.

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One early factor that led to increasing physician employment, at first mostly by hospitals and health systems, was the promise of data – especially big data – to drive better or more efficient care in institutional settings.[57] Some arguments for employment are still based on the hope that patient care can be better managed in more integrated settings.

A more skeptical take, though, is that doctors are now subject to an extremely complicated system of reimbursement, and lay managers can better navigate it.[58] When for-profit corporations take over nonprofit hospitals, for example, billing goes up even if there are no changes in the actual care provided.[59]

9.3.1.2 United Is No Longer Just an Insurer

Meanwhile, it's not just the share of physicians who are employed that is changing; it's also who employs them. Although most physician employment is still by hospitals, the fastest-growing segment is by corporate groups, including insurers and private equity firms.[60] In 2021, UnitedHealth Group, under its OptumHealth Unit, employed or controlled (in whole or part) over 53,000 doctors, about 5 percent of US physicians, more than the largest US health systems (Ascension, HCA Healthcare, and Kaiser Permanente).[61] This piece of United's overall business is expanding quickly, tripling its revenue from 2015 to 2020.[62] Other insurers including Humana Corp. and CVS Health Corp., which owns Aetna, are also expanding into health care delivery.

These insurers often pay doctors through value-based arrangements, and recent acquisitions focus on primary care doctors who are gatekeepers to the health care system. This strategy is especially important for Medicare Advantage business, which is the private health plan option for Medicare enrollees. In Medicare Advantage, health plans are paid a fixed amount per month per enrollee who selects their plans, but this amount can be adjusted upward through a risk-adjustment payment if the enrollee is identified by a provider as higher risk.[63] Corporations game

[57] Jost, *supra* note 12, at 838.

[58] Independent practices must employ an increasing number of administrative staff to navigate this complexity. Robert Kocher, *The Downside of Health Care Job Growth*, Harv. Bus. Rev. Online (Sept. 23, 2013), https://hbr.org/2013/09/the-downside-of-health-care-job-growth (last accessed Feb. 18, 2025).

[59] Elaine M. Silverman et al., *The Association between For-Profit Hospital Ownership and Medicare Spending*, 341 New Eng. J. Med. 420 (Aug. 5, 1999), https://www.nejm.org/doi/full/10.1056/NEJM199908053410606 (last accessed Feb. 18, 2025).

[60] Kane, *supra* note 53, at 16; Avalere Health, *supra* note 54, at 13.

[61] Tozzi, *supra* note 51.

[62] *Id.*

[63] Martha Hostetter & Sarah Klein, *Taking Stock of Medicare Advantage: Risk Adjustment*, Commonw. Fund Blog (Feb. 17, 2022), https://www.commonwealthfund.org/blog/2022/taking-stock-medicare-advantage-risk-adjustment (last accessed Feb. 18, 2025).

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risk-adjustment payments and increase reimbursement, in part by encouraging doctors to indicate that patients are sicker.[64]

Now, over half of Medicare's sixty-five million enrollees select a private plan and, eventually, it is likely all will.[65] The top players in Medicare Advantage, measured by share of enrollees,[66] are among the most active physician practice acquirers, focusing on those physicians who are in a position to influence risk-adjustment payments.

9.3.1.3 The Entrance of Private Equity

Other outside investors, including private equity firms, have been the most recent and aggressive entrants. Private equity firms will extract at least some of the wealth the medical profession labored to create as they seek profit. Regulators are taking notice, slowly.[67]

In some sectors, the influx of private equity capital might be beneficial, but in health care (and other fields like law where labor intensity produces value), it is harder to see the promise. As one report put it, private equity is "focused on short-term revenue generation and consolidation and not on the long-term wellbeing of patients. This in turn leads to pressure to prioritize revenue over quality of care, to overburden health care companies with debt, strip their assets, and put them at risk of long-term failure."[68]

A major problem is that corporate investors can profit without improving patient care.[69] Private equity firms have a short investment lifespan of generally ten or fewer years, during which the best way to achieve a higher sales price is through consolidation, which produces two benefits. First, larger networks of providers have more bargaining power to demand higher prices. Second, larger companies earn a higher multiplier when sold, just on account of being larger.[70]

Private equity investment in health care has accelerated dramatically over the past decade. Although it can be difficult to estimate because not all deals are reported,

[64] *Id.*

[65] Nancy Ochieng et al., *Medicare Advantage in 2024: Enrollment Update and Key Trends*, Kaiser Fam. Found. (Aug. 8, 2024), https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2024-enrollment-update-and-key-trends/ (last accessed Feb. 24, 2025).

[66] *Id.* (UnitedHealth [29 percent share]; Humana [18 percent share]; and CVS Health [11 percent share]).

[67] Annie Railton et al., *PE Investment in Healthcare Attracting Greater Federal Scrutiny*, N.Y. L.J. (June 30, 2021), https://www.goodwinlaw.com/-/media/files/news-and-events/press-posts/07_02-nylj-pe-healthcare-fca.pdf (last accessed Feb. 18, 2025); *see also* Erin Fuse Brown & Mark Hall, *Private Equity and the Corporatization of Health Care*, 76 Stan. L. Rev. 527 (Mar. 2024).

[68] Richard M. Scheffler et al., *Soaring Private Equity Investment in the Healthcare Sector: Consolidation Accelerated, Competition Undermined, and Patients at Risk* 2, AAI (2021), https://publichealth.berkeley.edu/wp-content/uploads/2021/05/Private-Equity-I-Healthcare-Report-FINAL.pdf (last accessed Feb. 20, 2025).

[69] *Id.* at 6.

[70] *Id.* at 7.

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one source estimates that annual deals increased from $45 billion in 2010 to nearly $120 billion in 2019.[71] Health care accounted for nearly 20 percent of reported private equity deals in 2020, making it the second-largest sector for investment.[72] A large majority of private equity buyouts are of clinics and outpatient care, followed by elder and disabled care.[73]

Private equity is driving consolidation in outpatient care, rolling smaller physician groups into large national companies.[74] One target has been physician staffing services that themselves aggregate physicians and contract with hospitals that need hospitalists, emergency medicine doctors, and anesthesiologists.[75]

Consider one example featured in a recent report.[76] Advanced Dermatology and Cosmetic Surgery (ADCS), founded in Florida in 1989, is a physician practice management firm that began to buy up physician practices in 2009. Private equity firm Audax acquired ADCS and added dozens of additional physician practices.[77] ADCS is now the largest dermatology practice across 12 states with 145 physician partners and 1.5 million patient visits a year.[78] Audax sold to another private equity firm, and likely made money simply by growing ADCS' revenue, even with no improvements in care.[79] For patients, this type of consolidation often makes health care less personal and more expensive.

Private-equity-driven consolidation is pervading primary care too. In Medicare Advantage, the private equity-funded aggregators described above gather physicians into networks. They are then acquired, often by Medicare Advantage organizations. For example, Oak Street's was acquired in February 2023 by CVS Health for $10.6 billion and One Medical by Amazon for $3.9 billion as part of a possible strategy of entering Medicare Advantage.[80] The companies can use these relationships to steer patients from public Medicare to their private Medicare

[71] *Id.* at 2; *see also* Eileen Appelbaum & Rosemary Batt, Inst. for New Econ. Thinking, Private Equity Buyouts in Healthcare: Who Wins, Who Loses? (2020).
[72] Scheffler et al., *supra* note 68, at 8 (using data from PitchBook).
[73] *Id.* at 11.
[74] *See, for example*, Jane M. Zhu et al., *Private Equity Acquisitions of Physician Medical Groups across Specialties, 2013–2016*, 323 JAMA Rsch. Letter 663 (Feb. 18, 2020).
[75] Appelbaum & Batt, *supra* note 71, at 56–66.
[76] Scheffler et al., *supra* note 68, at 26.
[77] *Id.* at 26–27.
[78] Harvest Partners, *Advanced Dermatology & Cosmetic Surgery*, https://www.harvestpartners.com/advanced-dermatology-cosmetic-surgery (last accessed Sept. 13, 2023). Note that these large firms evade antitrust scrutiny because they grow through small deals, none of which is large enough to trigger Hart Scott Rodino's review.
[79] Scheffler et al., *supra* note 68, at 30, 33.
[80] Michelle F. Davis et al., *CVS Pays $10.6B for Oak Street Health Primary Care Centers*, ALM Benefits Pro (Feb. 8, 2023), https://www.benefitspro.com/2023/02/08/cvs-pays-10-6b-for-oak-street-health-primary-care-centers/ (last accessed Feb. 20, 2025); Heather Landi, *Amazon Closes $3.9B One Medical Deal as It Builds out Healthcare Strategy*, Fierce Healthcare (Feb. 22, 2023), https://www.fiercehealthcare.com/providers/amazon-closes-39b-one-medical-deal-build-its-ambitions-healthcare-player (last accessed Feb. 20, 2025).

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Advantage plans where doctors become a key to profitmaking through risk adjustment, as discussed above.[81]

9.3.2 *Change Emerges: Possibly Too Little Too Late*

In recent years, physicians and their priorities have noticeably shifted. Physicians are trying to regroup and regain control over their professional lives through labor efforts including unionization. And laws aimed at turf protection have begun to recede, hastened by the COVID-19 pandemic. These efforts may be too late, however, to redirect the trajectory of the profession.

So far, this chapter has portrayed doctors and the profession as monolithic, which was untrue even in the days when most doctors were male, white, politically conservative members of the AMA, and the AMA spoke on their behalf on policy. In recent decades, doctors have become much more heterogeneous.[82] Doctors are seeking more varied ends out of medical practice. They are more than ever prioritizing work-life balance more than or co-equal to other career goals.[83] The AMA's power and membership has declined, evident during ACA debates when new groups like Doctors for America spoke on behalf of an emerging progressive and public health-oriented wing of the profession.[84] And even the AMA seeks to evolve. In June 2019, the AMA nearly passed a proposal to eschew opposition to single-payer health care reform.[85]

The COVID-19 pandemic hastened health policy reforms, undoing many of the overly restrictive laws that produced a glaring shortage of primary care doctors in many communities. For example, all fifty states temporarily waived in-state licensure requirements, which allowed providers to cross state boundaries to practice, and all but one applied this waiver to telehealth too.[86] Most states with restrictive scope-of-practice laws allowed nonphysician providers to do increasingly more, practicing to the top of their training and ability, rather than to an artificially set boundary.[87]

[81] Richard Kronick, *Projected Coding Intensity in Medicare Advantage Could Increase Medicare Spending by $20 Billion Over Ten Years*, 36 Health Affs. 320 (2017).

[82] *Doctor Demographics and Statistics in the US*, Zippia, https://www.zippia.com/doctor-jobs/demographics/ (last accessed Aug. 29, 2023).

[83] NEJM Career Center, *Understanding Millennial Physician Job Seekers: An Updated Look* 8 (2022), http://resources.nejmcareercenter.org/wp-content/uploads/MillennialStudyUpdate2022.pdf (last accessed Feb. 20, 2025).

[84] Doctors for America, *What We Do, Doctors for America*, https://doctorsforamerica.org/what-we-do/ (last accessed Mar. 13, 2023).

[85] Abigail Abrams, *A New Generation of Activist Doctors Is Fighting for Medicare for All*, Time (Oct. 24, 2019).

[86] Allison K. Hoffman & Simone Hussussian, *Covid-19 and Access to Medical Care in the United States*, Reg. Rev. (May 26, 2020), https://www.theregreview.org/2020/05/26/hoffman-hussussian-covid-19-access-medical-care-united-states/ (last accessed Feb. 20, 2025).

[87] Am. Ass'n of Nurse Practitioners, *COVID-19 State Emergency Response: Temporarily Suspended and Waived Practice Agreement Requirements*, https://www.aanp.org/advocacy/state/covid-19-state-emergency-response-temporarily-suspended-and-waived-practice-agreement-requirements (last accessed Mar. 12, 2023).

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Some, although a small minority of, states made these expansions to scope-of-practice permanent.[88]

The boundaries of medical practice continue to shift after the pandemic. In the first months of 2023, state lawmakers introduced 200 bills that would, for example, allow pharmacists to administer vaccines or prescribe hormonal contraceptives and that would allow optometrists to inject local anesthesia for minor procedures.[89] Likewise, both the federal and the state governments relaxed laws on telemedicine.[90] And some states, and Medicare, created parity rules for reimbursing telehealth and in-person visits the same amounts.[91]

But rebuilding the profession with a more capacious vision of who is part of it may prove impossible after the effects of over a century of protectionism. Nurses are leaving the profession, and nursing shortages are increasingly acute.[92] In turn, private equity is buying up travel nursing agencies that place nurses in high-need areas across the country at a premium.[93] It seems that current efforts to increase access to care and redefine the bounds of the profession may be limited by a path set in motion a century prior.

9.3.3 *The Impact of the Fall of the Medical Profession on Patients*

This chapter focuses on the medical profession and its regulation, but anyone who has been a patient knows who loses in the end when regulation is motivated by factors other than access to high-quality care. It has been evident for some time that the profession depressed supply and access to care in harmful ways, especially in low-income and rural areas, and efforts to turn the tide are likely insufficient to make up for a century of contraction.

What is more recently surfacing is that the increasing corporatization of health care delivery is also bad for our health. Physicians report pressure to provide more care by reducing the time with each patient, detracting from the quality of care in some cases.[94] The rise of the corporatization of health care has led to providers

[88] *Id.* (reporting that Massachusetts, Maine, New York, Nebraska, and Kansas made permanent or are considering making permanent waivers of practice agreement requirements).

[89] Daniel Payne, *The _____ Will See You Now: How the Pandemic Could Change Who Treats You*, POLITICOPRO (Apr. 11, 2023), https://subscriber.politicopro.com/article/2023/04/the-will-see-you-now-how-the-pandemic-could-change-who-treats-you-00091256 (last accessed Feb. 20, 2025).

[90] Hoffman & Hussussian, *supra* note 86.

[91] *Id.*

[92] *Id.*

[93] Mary Bugbee, *Profiting in Crisis: Exploring Private Equity's Investments in Travel Nursing Amidst a Critical Nursing Shortage and a Pandemic*, PRIVATE EQUITY STAKEHOLDER PROJECT (2022), https://pestakeholder.org/wp-content/uploads/2022/10/PE_travelnursing_FINAL-1.pdf (last accessed Feb. 20, 2025).

[94] Mark W. Friedberg et al., *Factors Affecting Physician Professional Satisfaction and Their Implications for Patient Care, Health Systems, and Health Policy*, 3 RAND HEALTH Q. 1

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feeling they must fit more "billable" patients into shorter increments of time, resulting in care that they feel is insufficient or even unethical and increasing cynicism among providers.[95]

Subjective patient experience suffers. Data from the Harris Poll indicates that more than 70 percent of adults feel the health care system is failing to meet their needs in at least one way.[96] Examples of this failure include the length of waiting time to schedule an appointment, coordinating across several providers, and not understanding recommendations from health care providers.[97]

Meanwhile, the United States has fallen farther behind peers in common health metrics such as life expectancy at birth and infant mortality.[98] Disease burden, which takes into account both premature death and years of living with disability, is higher in the United States than elsewhere.[99] The United States also ranks last among its peer countries in measures of health access and quality, negatively impacting population health.[100] The United States has among the lowest rates of physician visits and lowest number of hospital beds in the world, yet its health care spending is the world's highest.[101]

Specific evidence on corporate ownership is not encouraging either. Medicare Advantage plans are driving up the cost of Medicare without adding concomitant value. These private plans profited early on by enrolling healthier populations.[102] Most have been accused of fraud by whistleblowers and/or the government.[103] They fail to serve patients with complex health needs,[104] and their enrollees are more

(2014), https://www.rand.org/pubs/periodicals/health-quarterly/issues/v3/n4/01.html (last accessed Feb. 20, 2025).

[95] Marie G. Rudden, *"A Weird Culture of Coercion": The Impact of Health Care Corporatization on Clinicians*, 19 Int'l J. Applied Psychoanalytic Stud. 270 (2022).

[96] Am. Acad. of Physician Assistants, *The Harris Poll*, https://www.aapa.org/research/patient-experience/ (last accessed Sept. 13, 2023); Jamie Ducharme, *More than 70% of Americans Feel Failed by the Health Care System*, Time (May 16, 2023).

[97] *Id.*

[98] Nisha Kurani & Emma Wager, *How Does the Quality of the U.S. Health System Compare to Other Countries?*, Peterson-KFF Health Sys. Tracker (Sept. 30, 2021), https://www.healthsystemtracker.org/chart-collection/quality-u-s-healthcare-system-compare-countries/ (last accessed Feb. 20, 2025).

[99] *Id.*

[100] *Id.*

[101] Munira Z. Gunja et al., *U.S. Health Care from a Global Perspective, 2022: Accelerating Spending, Worsening Outcomes*, Commonwealth Fund (Jan. 31, 2023), https://www.commonwealthfund.org/publications/issue-briefs/2023/jan/us-health-care-global-perspective-2022 (last accessed Feb. 20, 2025).

[102] Randall S. Brown et al., Mathematica Pol'y Rsch Inc., The Medicare Risk Program for HMOs: Final Summary Report on Findings from the Evaluation xvii–xx (Feb. 18, 1993).

[103] Reed Abelson & Margot Sanger-Katz, *The Cash Monster Was Insatiable': How Insurers Exploited Medicare for Billions*, N.Y. Times Upshot (Oct. 8, 2022), https://www.nytimes.com/2022/10/08/upshot/medicare-advantage-fraud-allegations.html (last accessed Feb. 20, 2025).

[104] David J. Meyers et al., *Analysis of Drivers of Disenrollment and Plan Switching among Medicare Advantage Beneficiaries*, 179 JAMA Internal Med. 525 (2019).

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likely to enter lower-quality nursing home facilities.[105] Evidence suggests that Medicare Advantage plans are wrongly denying care in as much as one-fifth of cases, threatening the viability of rural hospitals.[106]

As another example, early evidence on private equity investment in physician practices suggests that patients may end up paying more or getting unnecessary care. A Kaiser Health News investigation of private-equity-owned outpatient care reported $500 million in False Claims Act settlements for overbilling, and a series of articles uncovered stories of unnecessary and poor-quality care, including of a two-year-old who died after a private-equity-owned dental clinic performed unnecessary root canals and placed crowns on baby teeth.[107] A study in JAMA of 578 private equity-acquired physician practices in dermatology, gastroenterology, and ophthalmology showed increases in health care spending and use.[108] In the case of dermatology and ADCS, noted above, after private equity investment, dermatology practices refocused on the sale of retail skincare products and self-pay elective procedures, and employees reported that the company cut back on essential supplies and provided care with questionable value and safety.[109] Research suggests that nursing homes with private equity ownership produce lower quality of care – including increased emergency department visits and hospitalizations for patients – at higher prices.[110] And a shocking recent study revealed a 25 percent increase in preventable hospital-acquired injuries – like falls and central line or surgical site infections – after private equity hospital acquisitions.[111]

[105] David J. Meyers et al., *Medicare Advantage Enrollees More Likely to Enter Lower-Quality Nursing Homes Compared to Fee-For-Service Enrollees*, 37 Health Affs. 78 (2018).

[106] Gretchen Morgenson & Lisa Cavazuti, *By Denying Claims, Medicare Advantage Plans Hurt Rural Hospitals, Say CEOs*, NBC News (Dec. 15, 2023), https://finance.yahoo.com/news/denying-claims-medicare-advantage-plans-123041741.html (last accessed Feb. 20, 2025).

[107] Fred Schulte, *Sick Profit: Investigating Private Equity's Stealthy Takeover of Health Care across Cities and Specialties*, KFF Health News (Nov. 14, 2022), https://kffhealthnews.org/news/article/private-equity-takeover-health-care-cities-specialties/ (last accessed Feb. 20, 2025).

[108] Yashaswini Singh et al., *Association of Private Equity Acquisition of Physician Practices with Changes in Health Care Spending and Utilization*, 3 JAMA Health F. e222886 (2022), https://jamanetwork.com/journals/jama-health-forum/fullarticle/2795946 (last accessed Feb. 20, 2025) (reporting an average 20 percent increase in charges per claim and a 16.3 percent increase in number of encounters).

[109] Scheffler et al., *supra* note 68, at 34; Katie Hafner & Griffin Palmer, *Skin Cancers Rise, Along with Questionable Treatments*, N.Y. Times (Nov. 20, 2017), https://www.nytimes.com/2017/11/20/health/dermatology-skin-cancer.html (last accessed Feb. 20, 2025).

[110] *See, for example*, Atul Gupta et al., Nat'l Bureau of Econ. Rsch., Owner Incentives and Performance in Healthcare: Private Equity Investment in Nursing Homes (2021), https://ssrn.com/abstract=3790212 (last accessed Feb. 20, 2025) (showing 10 percent increases in short-term mortality of Medicare patients with private equity ownership of nursing homes, or 20,150 lives lost due to private equity ownership over twelve years, declines in other measures of well-being including mobility, and a 11 percent increase in taxpayer spending per patient); Robert Tyler Braun et al., *Association of Private Equity Investment in US Nursing Homes with the Quality and Cost of Care for Long-Stay Residents*, 2 JAMA Health F. e213817 (2021).

[111] Sneha Kannan et al., *Changes in Hospital Adverse Events and Patient Outcomes Associated with Private Equity Acquisition*, 330 JAMA 2365 (2023).

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In the end, patients suffer as medicine overly focuses on profits. When profit seeking is imposed through external controls and management, it becomes increasingly difficult for doctors and others to provide any counterbalance, regardless of their own intentions or motivations.

9.4 THOUGHTS FOR THE LEGAL PROFESSION

How does the legal profession avoid the fate of the medical profession? Initially, law and medicine progressed in step. Over the past century, law has used many of the same tools as medicine to protect profits and bolster professional standing: restrictive supply requirements with accreditation limiting the pool of lawyers, which, like the supply restrictions in medicine, had a disproportionate effect on women and underrepresented minorities; licensure laws for turf protection; bans on corporate ownership; and strict supervision requirements for lawyer extenders such as legal assistants and paralegals. The American Bar Association (ABA) sought control in the same way the AMA did, with only one letter's difference.

Yet, today's legal profession looks very different from medicine. Lawyers are still the only ones who can practice law. Law has largely resisted entry of outside investors like private equity, and, although insurance also plays a key role in modern legal practice, it is as a client to firms, not as an owner of them. Many lawyers are not employees, and those who are employed tend to be employed by their fellow lawyers, organized under a partnership model or by cities, states, or the federal government.

Still, in law, many are advocating for the abolition of Rules 5.4(b) and (d), which prevent fee-sharing and nonlawyer ownership. The forward-looking question is this: How does the legal profession improve access to legal services without opening the portals that devoured the medical profession? Since I come to this volume as an interloper in the access-to-justice conversation, I end with loosely formed thoughts on how the arc of the medical profession might frame some hard questions for the legal one about practice authority and capital. These are intended as beginning questions, not as answers.

9.4.1 *Who Can Practice? Questioning the Boundaries of the Profession*

One hypothesis running through this chapter is that the medical profession was too restrictive when shaping the bounds of practice authority. Contraction of medical education and narrow practice rules might have rooted out some bad practices of medicine, but when people can't see a doctor, it can quickly become a crisis.[112]

To address shortages, the profession allowed "physician extenders," assuming that they would never be a good substitute for a doctor and that physicians could control

[112] STARR, *supra* note 2, at 382.

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them. Yet, as evidence emerged that an advanced practice nurse can provide good care, independent of a doctor, justifications for control dissipated.

Maybe law has not yet found the tipping point of an access crisis, but if it hasn't, it may be nearing one. The number of people who have unmet need for legal assistance has surged.[113] At this pivotal moment, the legal profession and the ABA can still help to shape a solution that thoughtfully considers the role of paraprofessionals, nonlawyer professionals, and technology including artificial intelligence, rather than being an impediment to it.

Medicine suggests that holding on too tight to the boundaries of practice might lead to a short-term boon but a long-term unraveling. So, a first reflection is: If the legal profession embraces a more capacious model of legal services, can broader practice authority be part of the solution, rather than an impediment to be overcome?

9.4.2 *How to Fund Access to Legal Services*

Even if more people could offer legal services in various forms, the harder challenge is an external one of how to fund legal services for people who cannot afford them (which is most people). And perhaps the lesson of medicine in this space is that there is no easy answer.

Legal aid societies have existed since the mid-nineteenth century, shifting through various models and funding sources over time.[114] By 1965, most major cities in the United States had some formal, local legal aid program.[115] Most adopted a traditional model of charitable, individualized, case-by-case assistance.[116]

The Economic Opportunity Act of 1964 (EOA) marked the first time Congress provided federal funding for legal aid.[117] The Act created the Office of Economic Opportunity (OEO) to administer EOA funds,[118] which relied on local community

[113] L. Servs. Corp., *The Justice Gap Report* (2022), https://www.lsc.gov/our-impact/publications/other-publications-and-reports/2017-justice-gap-report (last accessed Feb. 20, 2025).

[114] Scott Cummings & Jeffrey Selbin, *Poverty Law: United States*, *in* International Encyclopedia of the Social & Behavioral Sciences 3 (James D. Wright ed., 2015); William P. Quigley, *The Demise of Law Reform and the Triumph of Legal Aid: Congress and the Legal Services Corporation from the 1960's to the 1990's*, 17 St. Louis U. Pub. L. Rev. 241, 244 (1998).

[115] Alan Houseman & Linda E. Perle, Securing Equal Justice for All: A Brief History of Civil Legal Assistance in the United States 8 (2018); Shaun Ossei-Owusu, *Civil vs. Criminal Legal Aid*, 94 S. Cal. L. Rev. 1573 (2021) (describing the first cities to establish legal aid organizations outside of New York, Boston, and Chicago).

[116] Houseman & Perle, *supra* note 115, at 8. A minority at times sought systemic changes in the law.

[117] Cummings & Selbin, *supra* note 114, at 3–4.

[118] Note, *The Legal Services Corporation: Curtailing Political Influence*, 81 Yale L.J. 231, 236 (1972); Cummings & Selbin, *supra* note 114, at 3; Clinton Bamberger, *Legal Services Program of the Office of Economic Opportunity*, 41 Notre Dame L. Rev. 847, 852 (1966); Quigley, *supra* note 114, at 245.

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action agencies to disburse these funds. Private attorneys opposed OEO models on several grounds, including that with federal funding might come the specter of greater regulation of the legal profession.[119]

In 1971, an ABA committee recommended the creation of a private, nonprofit corporation that would replace OEO.[120] And a 1974 law succeeded with the creation of the Legal Services Corporation (LSC), a nonprofit corporation headed by an independent, bipartisan board.[121] After a brief rise, however, Congress began to limit the use of LSC funding, culminating in the election of Ronald Reagan in 1980 who proposed its complete elimination.[122] President Reagan failed to achieve this vision, but LSC has been on a funding roller coaster since.[123]

Some bar associations endorsed an alternative, middle-ground proposal for federally funded legal aid: Judicare.[124] Judicare would have used federal funds to pay for poor clients to seek private services, like Medicare and Medicaid.[125] But John Robb, the then-Chairman of the Standing Committee on Legal Aid and Indigent Defendants of the American Bar Association, rejected following the path of medicine, arguing presciently in 1967 that doctors may "have paid too high a price for what may well prove to be a short lived prosperity."[126] Despite some testing of Judicare models, it never took hold in more than very limited ways.[127]

Instead of one, central funding model, various decentralized ones have emerged. On the criminal side, states and cities help to fund defense attorneys. On the civil side, for example, programs funded through interest on lawyers' trust accounts (IOLTA), the second-largest source of legal aid funding after LSC, pay for legal services using interest accrued from trust accounts in which lawyers hold client funds.[128] These programs were created by state rules of professional conduct, state legislatures, or state supreme courts, and have existed in every state and the District of Columbia since 1997.[129]

[119] *See* Bamberger, *supra* note 118, at 849; John D. Robb, *Alternate Legal Assistance Plans*, 14 Cath. Law. 127, 138 (1968).
[120] Houseman & Perle, *supra* note 115, at 21.
[121] *See* Legal Services Corporation Act of 1974, Pub. L. No. 93-355, 88 Stat. 378 (1974).
[122] Cummings & Selbin, *supra* note 114, at 8.
[123] Quigley, *supra* note 114, at 261; Cummings & Selbin, *supra* note 114, at 8; Carl Rauscher, *LSC Requests $1.5 Billion to Confront Widening Justice Gap amid Pandemic Hardships*, Legal Servs. Corp. (Mar. 9, 2023), https://www.lsc.gov/press-release/lsc-requests-15-billion-confront-widening-justice-gap-amid-pandemic-hardships (last accessed Feb. 20, 2025).
[124] *See* Joseph F. Preloznik, *Wisconsin Judicare: An Experiment in Legal Services*, 57 A.B.A. J. 1179, 1179–80 (1971).
[125] Robb, *supra* note 119, at 128.
[126] *Id.* at 140.
[127] Houseman & Perle, *supra* note 115, at 27.
[128] *Id.* at 43.
[129] Andrew Arthur, Comment, *A Good Rule, Poorly Written: How the Financial Crisis Highlighted the Inadequacy of IOLTA Rate Rules*, 64 Cath. U. L. Rev. 729, 732–33, 745 (2015); Hillary A. Webber, *Note, Equal Justice under the Law: Why IOLTA Programs Do Not Violate the First Amendment*, 53 Am. U. L. Rev. 491, 496 (2003).

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The United States spent over $4.5 trillion on health care in 2022, including over $1 trillion on professional services, such as physician and clinical services.[130] In contrast, the entire legal services market is not even $400 billion. And total legal aid funding including LSC and IOLTA was just $2.8 billion in 2021, barely a drop in the bucket.[131]

Although the lack of federal funding impedes access to justice, lessons from medicine suggest it also avoids traps. Medicare and Medicaid brought an infusion of federal money into health care and, with it, a host of problems including steep health care cost inflation, which regulators have lacked the reach and the will to curb. Instead, they turn to market competition with hopes that it will do so, handing over program administration to corporate participants in those markets. With some exceptions, these efforts have failed to save money or improve care quality; in fact, they've done the opposite.[132]

Maybe uniform federal funding would have avoided these traps. If, in 1965, Congress had passed a national health insurance system, we might see more coherent price regulation where the greatest friction occurs between regulators, on one hand, and doctors and hospitals, on the other, over reimbursement rates. The medical profession (ironically, considering the AMA's deep resistance to such an approach) might have fared better in that alternative world. But a partial solution in health care has accelerated the undermining of the profession.

This lesson from medicine suggests that the challenge for the law is how to get to funding levels that approach the need for legal services while resisting the problems that powerful, yet fragmented federal programs can create. This challenge is obviously formidable.

9.4.3 *Whether to Resist Corporatization*

A related question is whether to allow corporate money to fill shortfalls. Here, medicine's trajectory suggests the legal profession "proceed with caution." Had corporate practice of medicine prohibitions stayed in place and been enforced, corporate interests likely wouldn't have been excluded wholly, as evinced by the many workarounds of these laws. But at the same time, there likely would have been stronger legal teeth to resist dramatic corporatization.[133]

[130] Micah Hartman et al., *National Health Care Spending in 2022: Growth Similar to Prepandemic Rates*, 43 Health Affs. 6 (2024).

[131] ABArray National Data, *U.S. Funding for Legal Aid* (Nov. 30, 2022), https://public.tableau.com/app/profile/abarray/viz/ABArrayNationalData/NationalLegalAidFunding (last accessed Feb. 20, 2025).

[132] Allison K. Hoffman, *Health Care's Market Bureaucracy*, 66 UCLA L. Rev. 1926 (2019).

[133] *See* Brown & Hall, *supra* note 67, at 54 (considering whether corporate practice of medicine doctrine could be invoked to push back on private equity investment in health care).

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Prohibitions on corporate ownership in the law, in contrast, have been in place and effective for nearly a century. Every state bar association, except the District of Columbia, adopted ABA Rule 5.4, which prohibits nonlawyer ownership of law firms, despite having faced resistance among firms.[134]

Yet, recently, a few states have adopted reforms permitting nonlawyers to own law firms. Arizona eliminated Rule 5.4 on a permanent basis, whereas Utah began a two-year pilot period to experiment with allowing law firm ownership by nonlawyers.[135] In their wake, California and North Carolina established committees to investigate similar reforms.[136]

Law firms see eliminating Rule 5.4 as enabling new ways for them to access capital, which under the rule is only possible if equity partners invest more in the firm or through a bank loan.[137] Without Rule 5.4, external investors can buy equity in the firm, producing capital without debt.[138] Eliminating Rule 5.4 could also institutionalize adjacent legal competencies outside of law firms,[139] or allow marketing, tax planning, or wealth management entities to obtain ownership interest in legal services.[140]

Some thoughtful scholars and other stakeholders suggest that the elimination of Rule 5.4 could benefit lawyers and promote access to justice.[141] They highlight potential increases in consumer access to services and innovation in the legal market, and some early experimentation affirms this possibility.[142]

Yet, medicine offers a cautionary tale about lifting such barriers whole cloth, especially without monitoring which corporate interests can enter and how. Corporate investment in health care illustrates the unintended consequences that could follow if states are not careful about keeping a close eye on the precise form

[134] Conrad J. Jacoby, *Practice Innovations: Non-Lawyer Ownership of Law Firms – Are Winds of Change Coming for Rule 5.4?*, Reuters (Mar. 31, 2022), https://www.reuters.com/legal/legalindustry/practice-innovations-non-lawyer-ownership-law-firms-are-winds-change-coming-rule-2022-03-31/ (last accessed Feb. 20, 2025).

[135] Lyle Moran, *Arizona Approves Nonlawyer Ownership, Nonlawyer Licensees in Access-to-Justice Reforms*, A.B.A. J. (Aug. 28, 2020).

[136] Conn Kavanaugh, *Lawyer Ownership of Law Firms: Coming to a Jurisdiction Near You?*, JD Supra (June 3, 2021).

[137] Tyler Cobb, *Have Your Cake and Eat It Too! Appropriately Harnessing the Advantages of Nonlawyer Ownership*, 54 Ariz. L. Rev. 765, 776 (2012).

[138] *See, for example*, Brett Cole, *Slater and Gordon, Australian Law Firm, to Acquire Arm of Quindell of Britain*, N.Y. Times (Mar. 29, 2015); Brandon Kochkodin, *Why Law Firms Could Be Private Equity's Next Conquest*, Forbes (Feb. 26, 2024).

[139] Sara Merken, *Arizona Approves Five More Entities for New Legal Business Structure*, Reuters (Aug. 27, 2021).

[140] *Id.*

[141] *See, for example*, Jason Solomon et al., *How Reforming Rule 5.4 Would Benefit Lawyers and Consumers, Promote Innovation, and Increase Access to Justice*, Stan. Ctr. Legal Pro. (Apr. 2020); Ralph Baxter, *Dereliction of Duty: State-Bar Inaction in Response to America's Access-to-Justice Crisis*, 132 Yale L.J. F. 228, 235 (2022).

[142] David Freeman Engstrom et al., Legal Innovation after Reform: Evidence from Regulatory Change (2022).

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diversification takes. It might be that such reforms open the floodgates but, without sufficient consumer protections and regulations, do not meaningfully expand access to justice.

9.5 CONCLUSION

We may never know exactly what factor or factors caused the medical profession's decline. Maybe what lawyers should learn most is that working to preserve one's own turf and earnings, rather than focusing on what is best for clients, harms the core values that make something a profession. It matters less whether it was the medical profession's aggressive self-regulation or its defeat of national health insurance or its exertion of control over reimbursement. When a profession works to aggrandize power and wealth and, in the process, loses sight of why it was accorded professional respect in the first place, it has become less a profession and more a business. There is certainly a lesson there for lawyers.

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