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Routing

Medical Licensing An Obstacle to Affordable, Quality Care

by Shirley Svorny

Executive Summary

In the United States, the authority to regulate medical professionals lies with the states. To practice within a state, clinicians must obtain a license from that state's government. State statutes dictate standards for licensing and disciplining medical professionals. They also list tasks clinicians are allowed to perform. One view is that state licensing of medical professionals assures quality.

In contrast, I argue here that licensure not only fails to protect consumers from incompetent physicians, but, by raising barriers to entry, makes health care more expensive and less accessible. Institutional oversight and a sophisticated network of private accrediting and certification organizations, all motivated by the need to protect reputations and avoid legal liability, offer whatever consumer protections exist today.

Consumers would benefit were states to eliminate professional licensing in medicine and leave education, credentialing, and scope-of-practice decisions entirely to the private sector and the courts.

If eliminating licensing is politically infeasible, some preliminary steps might be generally acceptable. States could increase workforce mobility by recognizing licenses issued by other states. For mid-level clinicians, eliminating education requirements beyond an initial degree would allow employers and consumers to select the appropriate level of expertise. At the very least, state legislators should be alert to the self-interest of medical professional organizations that may lie behind the licensing proposals brought to the legislature for approval.

Shirley Svorny is professor of economics and chair of the Department of Economics at California State University, Northridge, and an adjunct scholar at the Cato Institute.

State licensing laws require physicians for tasks that could be performed by less-skilled professionals.

Introduction

In the United States, the authority to regulate medical professionals lies with the states. To practice within a state, clinicians must obtain a license from that state's government. State statutes dictate standards for licensing and disciplining medical professionals. They also list tasks clinicians are allowed to perform (called a clinician's "scope of practice"). One view is that state licensing of medical professionals assures quality. Another view is that licensing is ineffective and makes consumers worse off.

States first began to license physicians in the early part of the 20th century. In effect, states handed the administration of physician-licensing laws to state boards composed of physicians. Likewise, states vested oversight of medical school accreditation in the American Medical Association, which represents the interests of physicians.

Many observers have suggested that licensing laws give physicians too much power. Leading economists—including Nobel Laureate Milton Friedman and University of Chicago professor Reuben Kessel—have argued that state licensing laws unnecessarily restrict the supply of medical care.¹ In his 1963 article on health economics in the *American Economic Review*, Nobel Laureate Kenneth Arrow noted that state licensing laws were needlessly restrictive, requiring physicians to perform tasks that could be performed ably and less expensively by less-skilled professionals.² From this point of view, liberalizing state licensing laws could make health care more available and less expensive without harming quality.

It took growing healthcare costs to motivate partial liberalization. Following the passage of Medicare and Medicaid legislation in the United States in 1965, the demand for physician services increased dramatically. To keep costs down, politicians at the federal level reduced entry barriers for foreign-trained physicians.³ In 1972, nearly 45 percent of newly licensed physicians in the United States were foreign-trained, up from approximately 20 percent in the 1960s.⁴

Slowly, the states followed by expanding the scopes of practice of nonphysician clinicians. Many states adopted laws to allow nurse practitioners to practice independently and to prescribe controlled substances—tasks historically reserved for physicians. The fact that nonphysician clinicians could provide certain types of care for less money than physicians led to the broader use of such mid-level professionals in all aspects of health care.

Organizations representing mid-level clinicians—including nurse practitioners, physician assistants, nurse midwives, physical therapists, podiatrists, and optometrists, among many others—continue to advocate broader scopes of practice for their members, ostensibly to increase access to care. However, these same groups are less concerned about access to care when it comes to the role of other clinicians. And they are anxious to raise education requirements for new entrants to their professions. Such requirements clearly reduce access.

An important question is whether such determinations even belong in the political arena, where decisions are subject to intense lobbying by parties whose interests might not align with those of consumers. Researchers at the University of California, San Francisco, Center for the Health Professions observe, "Interest groups with strong lobbies play a significant role in shaping [scope-of-practice] legislation."⁵

Any group of mid-level clinicians that can sway legislators can get its scope of practice expanded or increase education requirements for new entrants. Alternatively, a powerful physician lobby can block changes to the scopes of practice of mid-level practitioners that would impinge on its members' turf.

In this paper, I argue that these determinations do not belong in the political arena. State oversight of medical licensing and scope of practice has negative consequences for consumers. Consumers would benefit were states to eliminate professional licensing in medicine and leave education, credentialing, and scope-of-practice decisions to the private sector and the courts.

The Importance of Mid-Level Clinicians

Nonphysician clinicians have made significant inroads in the practice of medicine, despite opposition from the American Medical Association and state medical associations. By 2004, there were more than 240,000 advanced practice nurses⁶ and 60,000 physician assistants⁷ working in the United States, compared with about 800,000 active physicians.⁸ These two professions did not exist prior to the 1960s.⁹ Medicare and Medicaid, which together account for nearly half of all health care spending in the United States,¹⁰ routinely reimburse nonphysician clinicians, including physical therapists, audiologists, optometrists, podiatrists, nurse anesthetists and many others, for a variety of tasks.

Today, 23 states permit nurse practitioners to practice independent of physician oversight or collaboration; the remaining states do not.¹¹ Most states allow nurse practitioners and physician assistants to prescribe controlled substances.¹² Though no states allow physician assistants to practice independently, it is not uncommon for physician assistants to have relative autonomy, conferring with a supervising physician as necessary.

Specialization is increasingly common among mid-level clinicians. For example, nurse practitioners training at the University of California, San Francisco, may choose from a wide variety of specialties, as listed below:¹³

- Acute Care
- Midwifery/Women's Health
- Acute Care Pediatrics
- Occupational and Environmental Health
- Adult Nursing
- Oncology
- Cardiovascular
- Pediatrics
- Advanced Community Health
- Neonatology
- Critical Care/Trauma
- Perinatology
- Family Practice

- Psychiatric/Mental Health
- Gerontology

In addition to nurse practitioners, advanced practice nurses include clinical nurse specialists, certified nurse midwives, and nurse anesthetists.

Despite the primary care emphasis in their education, many physician assistants work in specialty practices. The American Academy of Physician Assistants lists numerous specialty practices, as follows. None of these specialties are specifically licensed by the states.¹⁴

- Allergy and Immunology Medicine
- Oncology
- Cardiology
- Otolaryngology
- Dermatology
- Orthopedic Surgery
- Emergency Medicine
- Psychiatry
- Gastroenterology and Hepatology
- Radiology
- Nephrology
- Rheumatology
- Neurosurgery
- Pediatrics
- Obstetrics and Gynecology
- Surgery
- Occupational Medicine

Mid-Level Clinicians and Quality

By almost all accounts, the quality of services consumers get from nonphysician clinicians is at least on par with what they would get from a physician performing the same services. Dozens of peer-reviewed studies compare outcomes in situations where patients are treated by a physician, a physician assistant, or an advanced practice nurse. Outcomes appear similar¹⁵—an important factor, considering that nonphysician clinicians can provide many services at a much lower cost. There is also evidence that teams of clinicians outperform individual physicians. (Many physicians who are accustomed to working in teams are happy with the collaboration.)¹⁶

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American Medical Association's Council on Medical Education found that the peer-reviewed studies "almost uniformly conclude that . . . a non-physician clinician . . . can provide an acceptable level of care."¹⁷ The Council did note that some observers find serious flaws in the literature, including small samples, lack of control subjects, and failure to control for differences in the severity of illness treated by physicians and nonphysician clinicians. Nevertheless, physician groups are unable to point to studies showing worse health outcomes with mid-level clinicians. That may be the most persuasive evidence that the quality of care provided by nonphysician clinicians is on a par with that provided by physicians.

The Need for Workforce Flexibility

The flexibility to employ mid-level clinicians in new ways is an essential part of making medical care more affordable. As Harvard Business School professor Clay Christensen and his colleagues explain, "Many of the most powerful innovations that disrupted other industries did so by enabling a larger population of less-skilled people to do in a more convenient, less-expensive setting things that historically could be performed only by expensive specialists in centralized, inconvenient locations."¹⁸

Such disruption is already taking place in medicine. According to public health researcher and American Thoracic Society executive director Stephen Crane, "Fifty years ago . . . medicine was as much an art as a science. We've been able to codify a lot of that knowledge. That allows us to teach what's going on in a shorter period of time and to delegate that to others to perform."¹⁹

Hospitals and other providers use what workforce flexibility exists to determine the tasks a particular mid-level clinician may perform.²⁰ As their skills develop, mid-level clinicians are given greater responsibility and autonomy. Thus the effective delineation of their scopes of practice occurs outside the licensing process, and largely at the point of care. Tracy Klein, a clinical instructor of medicine at the Oregon Health and Sciences University, writes, "Experience and environ-

ment can and will stretch the [nurse practitioner's] knowledge and competence beyond that of the basic education level."²¹

The Indian Health Service (the federal health program for American Indians and Alaska Natives) grants clinical and prescribing privileges to physician assistants on the basis of education, training, experience, and current competence.²² Relatively flexible scopes of practice enable physician assistants to alleviate workforce shortages as they emerge. According to the American Academy of Physician Assistants, about 20 percent of PAs change jobs annually, often moving across specialties.²³

Despite the progress made in incorporating mid-level clinicians, licensing and scope-of-practice rules still restrict providers' ability to employ medical professionals to their full competence. Licensing restricts nurse practitioners and other mid-level clinicians whose competence exceeds the legislatively imposed scope of practice.

The Politics of Medical Licensing

Groups representing mid-level professionals are currently threatening to erode what little workforce flexibility exists. Like physicians in the early part of the 20th century, lobbying groups of mid-level clinicians are working to secure legislation that would allow them to stake a claim to specific areas of practice, excluding all others from providing services in those areas. In addition, many clinician groups are lobbying to increase education requirements for new entrants to their field. When government issues licenses to medical professionals, it creates a regulatory apparatus that organized clinicians can manipulate to increase their incomes.

Is More Education Always Better?

Mid-level medical professions have been successful in increasing the amount of education required to obtain a license. For example, states increasingly require new NPs to obtain a master's degree. All states require physical ther-

apists to have a master's degree.²⁴ The American Association of Colleges of Nursing wants states to require a Doctor of Nursing Practice degree of all new advance practice nurses by 2015.²⁵ A new law requires physician assistants to have a masters or higher degree to practice in Ohio.²⁶ Every state has required a master's degree of occupational therapists since 2007.²⁷

Starting in 2012, California will require new audiologists to have obtained a doctorate (Au.D.), raising concerns that the legislation would exacerbate a shortage of audiologists. The legislation followed a move by the American Speech-Language-Hearing Association, the organization that accredits college audiology programs, to require a doctorate for professional certification. Questioning both why California legislators rushed to comply and whether even a master's degree is necessary to test someone's hearing, the *Sacramento Bee* called the requirement for a doctorate an "extraordinary and costly mandate."²⁸

Ostensibly, increasing education requirements would improve quality. But the relationship between educational inputs and better health outcomes is not that straightforward. Stricter education requirements limit entry into the medical professions, increase prices, and reduce access to care, which can result in worse health outcomes.

As with the audiology legislation in California, it is not clear that those excluded by these higher barriers to entry would not be competent practitioners. When hiring, hospitals and other employers can and do specify the level of education or training required of clinicians. Not every job requires the same level of skills. Increasingly strict education requirements deprive health care providers of a range of education and training options from which to choose. Forcing providers to use more highly educated—and thus more costly—practitioners increases prices and limits access to care.

Scope-of-Practice Turf Wars

Debates among competing groups of clinicians over scopes of practice are increasingly common. In July 2003, the Federation of

State Medical Boards established a Special Committee on Scope of Practice noting that "scope-of-practice changes are among the most highly charged policy issues facing state legislators and health care regulators."²⁹

The American Medical Association has joined with other physician organizations (including state-level medical associations) to establish the Scope of Practice Partnership, an "organized medicine coalition" to monitor legislative efforts by other associations of health professionals.³⁰ The president of the American Medical Association, Ronald M. Davis, called the Scope of Practice Partnership a "watchdog of legislative, regulatory, and legal endeavors that seek to expand the scope of practice of non-physician providers into the practice of medicine."³¹

To counter efforts by organized medicine and the AMA's Scope of Practice Partnership in particular, a group of 34 organizations representing other licensed medical professionals formed the Coalition for Patients' Rights.³²

Acknowledging the difficulties in reviewing scope-of-practice proposals and determining appropriate scopes of practice for various professionals, several states have established legislative committees to study scope-of-practice proposals and make recommendations. Statutes in Arizona and Iowa address the scope-of-practice review process. Arizona's statute requires consideration of the reason increased scope of practice is sought, the impact on consumers' access to health care, and implications for the interstate migration of health care professionals.³³ In Virginia, the Board of Health Professions (with members from each of the 13 health regulatory boards in the state) evaluates regulatory proposals and recommends the appropriate level of regulation.³⁴ A Texas proposal (HB 3950) to establish a Health Professions Scope of Practice Review Commission failed in 2007.

In most cases, physicians (represented by the state medical association) are in one corner and organizations representing other clinicians are in the other.³⁵ But non-physician clinicians also step on each other's toes. For example, because of a strong nursing lobby that opposed the practice of physician

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assistants, Mississippi was the last state to allow physician assistants to practice.³⁶

Those groups that oppose broader scope for nonphysician clinicians call for extensive review by policymakers of scope-of-practice initiatives. For example, the guidelines set by the Federation of State Medical Boards calls for a “verifiable need” for the proposed change, along with a review of the “details, rationale, and ethics of any proposals to bypass licensing” and “the implications for other practitioners, and the effect on patient safety.”³⁷ That standard would present a formidable barrier to reform. It is noteworthy that the Federation’s desire for evidence runs in only one direction. The Federation only demands evidence of the patient-safety effects of proposed *expansions* of scope-of-practice rules. It does not call for evidence that the existing *limits* on midlevel clinicians’ scopes of practice enhance patient safety. There is no such evidence.

Today’s turf battles include a wide range of issues. Here are some examples:

- Optometrists seek to expand their scope of practice to include surgical procedures traditionally limited to ophthalmologists.³⁸
- Physical therapists want to be able to treat patients without a physician’s prior diagnosis.³⁹
- Physician-anesthesiologists seek to limit the scope of practice of nurse anesthetists.⁴⁰
- The American Medical Association opposes assessment and diagnosis of clinical and laboratory data by PhD clinical lab scientists.⁴¹
- Medical societies in California and Idaho amended naturopaths’ scope of practice to require physician supervision or collaboration.⁴²
- In Missouri, certified professional midwives aspire to work independent of physician collaboration.⁴³
- Despite physicians’ concerns about safety, California decided to expand the scope of practice for oral and maxillofacial surgeons to include elective facelifts,

rhinoplasties, and eyelifts.⁴⁴

Clinician groups that fail to achieve their goals through legislative means have found a second avenue to reform: working with state regulatory boards to alter scope-of-practice rules. Because it is expensive for physician groups to challenge board decisions in court, this path to scope-of-practice expansion is growing.⁴⁵ However, it is not always successful. In 2008 a Texas appeals court ruled that the Texas State Board of Podiatric Medical Examiners went beyond its power in 2001 when it expanded podiatrists’ scope of practice. The appeals court determined that such a change would need to come from the state legislature.⁴⁶

With all of these efforts, the concern for consumers is that licensing requirements and scope-of-practice determinations will reflect the political power of various clinician lobbies rather than the patient’s interest in affordable, quality care. For example, physician assistants now have prescribing authority over controlled drugs in 36 states, yet Alabama, Florida, Kentucky, and Missouri still do not allow physician assistants to prescribe any controlled substances.⁴⁷ As of 2001 physician assistants and nurse practitioners had parallel duties in many facilities in Louisiana, yet nurse practitioners were allowed to write prescriptions, whereas physician assistants were not.⁴⁸ Such outcomes are more likely the result of power politics than variation in the competence of physician assistants across states.

Licensing and scope-of-practice laws give the medical professions considerable control over whether other professions may compete with them. That frequently slows the spread of affordable care. Consumers are worse off if licensure and scope of practice laws unnecessarily limit access to care.

What Value Does Licensing Add?

State licensing boards’ duties include checking the credentials of medical professionals, disciplining errant practitioners, and

reporting their activities to the public. Yet, as will be explained in detail below, boards rely on private organizations for much of their credentialing activity, disciplinary efforts are largely ineffective, and consumers receive little information from licensing boards that helps them choose quality clinicians. It is legitimate to ask, what value does licensing add?

Checking Credentials

State boards establish education and training criteria (including post-graduate training) and require potential licensees to pass examinations to test their knowledge and skills. State boards also fingerprint applicants, checking criminal records with the Department of Justice and the Federal Bureau of Investigation. Credential verification and background checks account for a sizable share of state medical board spending.⁴⁹

State medical boards don't do all the work themselves. They rely heavily on private organizations that accredit education and training programs and credential individual clinicians. For example, unique state tests for physicians have given way to common national test, the United States Medical Licensing Examination (designed and administered by two independent, private organizations: the Federation of State Medical Boards and the National Board of Medical Examiners). To assess physician training, all states rely on the American Medical Association's accreditation of U.S. medical schools.

Likewise, states depend on the Accreditation Review Commission on Education for the Physician Assistant to assess training programs for physician assistants and on the National Board for Certification of Occupational Therapists' examination to assess the skills of occupational therapists. Many states rely on the American Nurses Credentialing Center, which credentials individuals across 26 categories of nurses and nurse practitioners (advanced practice nurses).⁵⁰ These are just a few of the outside organizations on which states rely. In the absence of licensing laws, these organizations would continue to provide valuable credential-

ing services.

Disciplining Poor Performers?

Discipline is the second task of state medical boards and takes up most of the time of board staff. Disciplinary efforts generally focus on resolving complaints filed by the general public. When state board members and managers of state board disciplinary efforts were surveyed in 2004–2005, however, they expressed the concern that public complaints are not a good indicator of serious problems with practitioners.⁵¹ Those surveyed felt that physicians, nurses, hospitals, and other providers would provide better leads. Yet medical professionals tend to under-report quality problems. According to one survey: "Forty-five percent of [physicians] with direct personal knowledge of a physician in their hospital group or practice who was impaired or incompetent did not always report that physician. Of those with direct personal knowledge of a serious medical error, 46 percent did not report that error to authorities on at least 1 occasion."⁵² Moreover, those who did report problem colleagues did not necessarily report them to a state medical board. Thus there are potentially many serious quality problems that licensing cannot even identify, much less remedy. Indeed, state medical boards "typically do not define prevention of injury as part of their responsibility."⁵³

A second problem confronting state boards is that it is very difficult and expensive to establish substandard care, incompetence, or negligence.⁵⁴ Expert witnesses and lawyers are expensive. State boards don't have sufficient time or money to investigate the large number of malpractice settlements and judgments.⁵⁵

As a result, state boards have a poor record of disciplining errant physicians. A study of Florida physicians with malpractice payouts over \$1 million found that only 16 percent had been sanctioned by the state medical board.⁵⁶ Among physicians who made 10 or more malpractice payments between 1990 and 2005, only *one-third* were disciplined by their state boards.⁵⁷

Further complicating the disciplinary

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process, state boards are reluctant to pull a license or make public the results of an investigation due to the financial consequences for the sanctioned professional. Just issuing formal charges against a physician, which become public record, affect a doctor's reputation and potential income.⁵⁸

As a result of these forces, formal disciplinary actions typically do not focus on improper or negligent care. Instead, the bulk of disciplinary actions involve inappropriate prescription of controlled substances, drug and alcohol abuse, mental illness, sexual improprieties and other issues.⁵⁹ Researchers have found a high rate of repeat offenders among physicians sanctioned by state medical boards, suggesting that licensing does not deal with offenders in an effective way.⁶⁰

Reporting Negative Outcomes to the Public?

The licensing system also comes up short in the area of reporting substandard care to the public. There are often long delays. California reports an average of 934 days in getting a case to judicial review.⁶¹ To avoid the high costs of lengthy hearings, boards routinely negotiate voluntary settlements for lesser offenses. In the Federation of State Medical Boards' database, the nature of the investigation is not recorded in more than 65 percent of cases that ended in sanctions between 1994 and 2002. In those cases, the state board and the physician entered an agreement without the physician being found guilty.⁶² These dynamics deny consumers information that would help them avoid low-quality physicians.

Licensing, then, does little to prevent clinicians from rendering improper or negligent medical care. Disciplinary actions are not primarily related to the quality of medical care per se, and many disciplinary actions are kept below the public radar. If, as some suggest, concerns about financial and reputational consequences diminish efforts to discipline clinicians formally or publicly, or encourage confidential consent agreements, then one might conclude that licensure offers more protection to malfeasant clinicians than to

consumers.

Consumer Protections Offered by the Market and the Courts

A closer look suggests that most patient protections are unrelated to state licensing.⁶³ Concern over reputation and potential liability for medical malpractice creates incentives for private efforts to assess clinician knowledge, skills and competence that well exceed those associated with state licensing. Indeed, health care providers regularly review information on their clinicians that is broader and more up-to-date than information associated with licensure. At the point of care, hospitals and other institutions dictate what services each individual clinician may provide. On top of that, the structure of medical malpractice liability insurance rates creates some incentives for providers to avoid medical errors and other negligent care.

Medical Malpractice Liability

Hospitals, health maintenance organizations, and other healthcare providers may be liable for negligence in the credentialing, selection, retention, and supervision of health professionals.⁶⁴ Courts have established that a hospital or health maintenance organization has a "non-delegable duty to select and retain only competent physicians [and] to oversee all persons who practice medicine" in its facility or system.⁶⁵ The courts have ruled that health-care organizations have a duty of proper selection and a duty to supervise clinicians.⁶⁶

Therefore, hospitals and other health care providers are legally liable for the actions of clinicians whose background and skills they have assessed. When a negligent clinician is employed by a health care organization, the courts may hold the employer liable.⁶⁷ Even if the clinician is not employed by the provider, the provider may still be liable if there is any reason for patients to think that clinicians are tied to a provider, such as when a hospital advertises the quality of its clinicians. Similarly,

managed care organizations may be liable for the actions of plan physicians.⁶⁸

Malpractice Insurers

Private malpractice insurers also protect consumers by providing guidance and incentives for hospitals, other facilities, and individual clinicians to improve the quality of care. Most insurance companies offer discounts to physicians or physician groups willing to engage in practices known to reduce medical errors. For example, Medical Liability Mutual Insurance Company offers a premium discount of 5 percent to physicians and surgeons who complete a qualified risk-management program.⁶⁹

Physicians with high claims experience may face premium surcharges (called “experience rating”) or may have to turn to surplus-line carriers, which impose high premiums, have large deductibles, and may restrict practice or require additional training or supervision.⁷⁰ A 1985 survey of physician-owned insurance companies (which cover about 60 percent of the market for malpractice insurance)⁷¹ found that these insurers penalize physicians who exhibit “negligence-prone behavior.” During a one-year period, 0.66 percent of physicians had their insurance pulled. Insurers restricted coverage for or sanctioned another .7 percent of policyholders, and another 1.8 percent faced premium surcharges or deductibles if they wanted to continue to be insured. The survey’s authors concluded that “the physician-owned companies are effective agents in identifying negligence-prone behavior . . . and play an important role in deterring substandard performance.”⁷² A study of malpractice premiums in Vermont found surcharges as high as 400 percent,⁷³ and all insurers reported having declined or refused to renew coverage for reasons that include a history of adverse claims.⁷⁴ A look at one California malpractice insurer’s rate filing shows the range of factors the insurer considers. Among other things, insurers impose surcharges for failed board examinations, lack of specialty board certification, lack of hospital privileges, and frequent malpractice claims.⁷⁵ These financial

penalties discourage negligent care and help drive out of business physicians who repeatedly put patients at risk.

Hospitals need to be concerned about malpractice liability as well. Like physician-owned malpractice insurance companies, hospitals are in a prime position to monitor and evaluate clinicians. Hospitals generally self-insure, so they bear the costs of malpractice directly, creating incentives to be selective about medical professionals they hire and incentives to monitor clinicians over time. When hospitals buy insurance, it is “highly experience rated,”⁷⁶ thus a history of claims will cause their premiums to rise.

Private Credentialing

As noted above, many services provided by state licensing boards are redundant to efforts taken at the point of care. Hospitals and other institutions don’t give clinicians free reign just because the clinician has a state license. A vice president of the Texas State Board of Podiatric Medical Examiners recently noted that the board is “only a licensing agency . . . We’re not a credentialing agency . . . *It’s up to the hospitals to decide who they’ll credential—and for what.*”⁷⁷

Hospitals, managed-care organizations, and other providers not only check the background of medical professionals to avoid liability for negligence but also to meet standards set by accrediting organizations and insurers. In addition, federal law requires hospitals to request information from the National Practitioner Data Bank at the time a health care practitioner applies for a position and then every two years. Among other things, the National Practitioner Data Bank includes entries on medical malpractice payments and whether a clinician has been denied privileges to practice in a hospital or other health care facility.⁷⁸

Hospitals and other facilities are accredited by the independent Joint Commission,⁷⁹ whose clinician credentialing standards are sufficiently extensive to meet federal Medicare and Medicaid requirements. Clinicians are asked for identifying information and a declaration of adverse legal actions and convic-

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tions.⁸⁰ Every organization accredited by the Joint Commission must meet standard HR 1.20, which requires a process in place “to ensure that a person’s qualifications are consistent with his or her job responsibilities.”⁸¹ Therefore, every hospital or other healthcare facility has policies and procedures that delineate each clinician’s scope of practice. These can be generic for groups of clinicians or written specifically for individual clinicians. The hospital medical staff observes and documents a clinician’s skills before approving the clinician as competent to practice. Clinicians are supervised both concurrently and retrospectively as the basis for granting hospital privileges.

Managed care organizations, preferred provider organizations, and other health plans are accredited by the National Committee for Quality Assurance. The NCQA requires these organizations to credential clinicians as well.⁸²

The demand for clinician-credentialing has grown to the point that a sophisticated industry now collects and verifies information about individual clinicians for hospitals and other clients. Credentials verification organizations (CVOs) verify clinicians’ training and experience, and periodically review claims and adverse judgments against health care professionals. In addition to verifying a clinician’s professional education and training, CVOs verify whether a clinician has been certified to prescribe controlled substances by the federal Drug Enforcement Agency, the clinician’s malpractice claims history, any Medicare or Medicaid sanctions, and the clinician’s work history. CVOs also monitor private actions against medical professionals, including loss of hospital privileges or other sanctions. To guide facilities and organizations in choosing a CVO, the NCQA—the same group that accredits managed care, health maintenance and preferred provider organizations—certifies independent CVOs.⁸³

The private, nonprofit Federation of State Medical Boards’ Credentials Verification Service offers a permanent repository for records for physicians and physician assistants:

Applicants who complete the verification process establish a permanent, lifetime portfolio of primary source verified credentials [that] can be used throughout the applicant’s career for state licensure, hospital privileges, employment, and professional memberships.⁸⁴

Private specialty board certification is another voluntary form of credentialing and quality certification more rigorous than state licensing. Private specialty boards administer exams to test physicians’ competence in a particular area of medicine; physicians may become board-certified in more than one specialty. According to the American Board of Medical Specialties, nearly 85 percent of U.S. physicians are independently certified by specialty boards.⁸⁵ In 2002, the 24 boards that are members of the American Board of Medical Specialties agreed to adopt common “Maintenance of Certification” standards. All boards are required to be in compliance by 2010. This new agreement not only requires a formal examination and an assessment of clinical skills in a supervised practice setting, but also periodic reevaluation.⁸⁶

In the United States and abroad (in the burgeoning medical tourism industry), board certification guides hospitals and health plans in assessing physicians and is recognized by consumers as an indicator of quality. Physicians often advertise their specialty-board certifications, and patients often search for board-certified physicians. The value of independent board certification is suggested by a national study that found that managed care organizations are more likely to contract with board-certified physicians than with non-board-certified physicians.⁸⁷

Nongovernmental organizations also certify the quality of nonphysician clinicians. As noted above, the independent National Commission on Certification of Physician Assistants certifies physician assistants. Another private group, the Accreditation Review Commission on Education for the Physician Assistant, accredits physician assistant programs. Many nurse prac-

tioners seek certification from the American Nurses Credentialing Center. The ANCC offers nursing certification in 26 different specialties. According to that organization, more than 75,000 advanced practice nurses are currently certified.⁸⁸ Other organizations that certify nurse practitioners include the National Certification Board of Pediatric Nurse Practitioners and Nurses, the National Certification Corporation for the Obstetric, Gynecologic and Neonatal Nursing Specialties, the American Academy of Nurse Practitioners, and the National Association of Nurse Practitioners in Women's Health.⁸⁹ These organizations are known in the medical community and serve as a guide in hiring nurses.

If state licensing were eliminated tomorrow, consumers would continue to be protected by this sophisticated network of well-known private organizations that accredit health care facilities and credential medical professionals.

Brand Names: Would Additional Protections Arise without Licensing?

In many industries, markets assure quality through brand names and reputation.⁹⁰ Consumers rely on brand names as a quality signal in markets for restaurants, clothing, automobiles, computers, and air travel. Thanks to brand names, a hungry traveler in a strange city knows exactly the quality of cuisine he will get if he walks into a McDonald's versus a Chili's or a P.F. Chang's China Bistro.

Brand names have played a smaller role in health care than in other industries, perhaps because of preemption by licensing boards and the perception of quality assurance associated with licensure. However, brand name and reputation are growing as a basis for quality assurance in health care markets. Health plans that combine insurance and health care delivery under one roof, such as Kaiser Permanente, stake their reputations on the quality of their providers. The Cleveland Clinic, the Mayo Clinic, and other facilities have national reputations and are putting them to use in telemedicine.⁹¹ Brand-name retail clinics, such as RediClinic and Minute

Clinic, offer first-line health care, are staffed by nurse practitioners, and are opening up in CVS, Target, and Wal-Mart stores across the United States. These organizations have enormous incentives to maintain quality to protect their reputations. For example, Minute Clinic boasts of its adherence to evidence-based medicine guidelines.⁹² Wal-Mart has bet on brand names as a proxy for quality in promoting its retail clinics. "The Clinic at Wal-Mart" brand will partner with local hospitals in "co-branded" walk-in clinics, relying on local hospitals' reputations to bring in consumers.⁹³ Without state licensing, brand names and reputation would play an even greater role in health care markets, such as by offering guidance to patients considering treatment in freestanding outpatient surgery centers.

Conclusion

Medical licensure fails to meet expectations in the area of discipline and consumer protection. State medical boards' disciplinary efforts can arguably be said to protect clinicians more than consumers. Many actions against clinicians are settled privately and after extended periods of time. Clinicians who have faced disciplinary actions often continue to practice, with no public disclosure of the reasons for the sanction. The persistent difference between the promise of licensing and its actual performance is summarized by one long-time observer of New York's licensing laws, who describes that state's statutory authority as "exemplary" but the state's use of that authority "shameful."⁹⁴

Reforms that fail to appreciate the propensity of licensing authorities to place physician protection ahead of patient protection seem destined to repeat the failures of licensing. Drs. Lucian Leape and John Fromson call for sweeping changes to existing quality assurance measures, including "explicit [national] performance standards of behavior and competence" for physicians. While those standards would be based, as it happens, on the voluntary Maintenance of

If state licensing were eliminated tomorrow, consumers would continue to be protected.

Patients have little to lose, but much to gain, from eliminating medical licensing.

Certification standards developed by the private American Board of Medical Specialties, Leape and Fromson propose that reform be initiated and ultimately enforced by state medical boards.⁹⁵ Little in the state boards' decades-long record of failing to protect consumers suggests that state boards are well-suited to this task.

Those who favor replacing state regulations with national standards argue that national standards would encourage geographic mobility of medical professionals. Yet national standards for medical professional licensing would be a mistake for two reasons. First, variations across states let us see what works and what doesn't, allowing for innovation. Second, a shift toward national standards would *increase* special interest influence over licensing, leading to greater entry restrictions and less access. Eliminating licensure entirely would increase mobility as well, and would be a better policy option.

Quality assurance in today's medical marketplace doesn't come from state medical boards but from the fear of medical malpractice liability and from market mechanisms such as malpractice insurers; independent certification agencies like the Joint Commission, specialty boards, and credentials verification organizations; consumer guides such as *Consumer Reports*, HealthGrades, and Angie's List; and insurers' and providers' interest in protecting their reputations and brand names. A clinician may have a degree from an elite school, but if he has not kept abreast of the medical literature or his skills have deteriorated, his state license does almost nothing to protect patients. According to Dr. Derek van Amerongen, Chief Medical Officer of Humana Health Plans of Ohio and Indiana: "People and the legislatures read way too much into licenses. They are extremely poor proxies for quality and knowledge."⁹⁶ Oversight of medical professionals by state medical boards is at best redundant to those quality protections provided by courts and market processes. Because licensing reduces access to care and may give consumers a false sense of security, it may in fact do more harm than good.

If there were no state licensing of medical professionals, consumers would search more and demand more information, as they do with other goods. Patients could obtain as much quality assurance as licensure provides—and more—simply by looking for a board-certified physician. Brand names would play an increasing role in assuring quality care.

Additional protections likely would arise beyond the consumer's immediate purview. Credentials verification organizations would check criminal records and verify clinicians' education, training, and performance on national exams.⁹⁷ The specific information provided by licensure is not difficult to verify privately. Competition among credentials verification organizations would place such information, and potentially more, in the hands of providers and consumers. As noted above, the specialty boards already have plans to increase their monitoring of the continuing competence of board-certified physicians. When patients are injured by incompetent or negligent physicians—as some inevitably will be—they will continue to have recourse to the courts. The potential for liability, concern over reputation and brand name, and evolving standards of care would put continuous pressure on health plans, facilities, and clinicians to improve quality.

Without legislatively mandated education requirements or scope-of-practice restrictions, hospitals and other providers could better adjust their workforces when demand shifts, or when opportunities arise to reduce costs—either by making care more convenient or by saving patients money—while maintaining quality. Patients have little to lose, but much to gain, from eliminating medical licensing.

If eliminating licensing is politically infeasible, some preliminary steps might be generally acceptable. States could immediately increase workforce mobility by recognizing clinician licenses issued by other states, or Congress could require states to do so. For midlevel clinicians, such as physician assistants, physical therapists, and audiologists, eliminating education requirements beyond an initial degree

(say a bachelors' degree) would let employers and consumers select the appropriate level of expertise. At the very least, state legislators should be alert to the self-interest of medical professional organizations that may lie behind the licensing proposals brought to the legislature for approval. When physician groups insist that changes in scope of practice be contingent upon evidence of improved outcomes, politicians should remember that, at present, there is no basis for the claim that patient safety is assured under the current system (an artificial construct of past legislative action) or the claim that patients are at greater risk when state regulation is relaxed.

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