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The Case for Medical Licensure

George J. Annas

Editorial

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by George J. Annas, J.D., M.P.H.

Locke *et al.* argue elsewhere in this issue that medical licensure should be abolished. Their reasoning is direct and seductive — but their free market cure is worse than the disease they describe. Their major premise, for example, is simply wrong: "Any governmental action that violates individual rights is improper." For this notion they cite the ultraconservative novelist Ayn Rand who talks about things that are "right" for humans to do. But there are two confusions: (1) rights do not exist in a vacuum; in an interdependent society the rights of individuals *must* sometimes be balanced against the rights of the group (*e.g.*, airport security screening or neighborhood police patrols); and (2) to say one has a right to do something is not the same as saying it is "right" for someone to do something (*e.g.*, I may have a right to treat an accident victim in an emergency, but if I know I will do more harm than good, it would be wrong for me to treat the victim). In Ayn Rand's society everyone has the "right" to do what he thinks is "right" without governmental interference. This is fine for the strong and wealthy; it is destructive to the middle-class majority and the poor. The world can only support a handful of Howard Rouarks and Dagney Taggarts.

The authors, do, however, correctly highlight the bastard pedigree of occupational licensing. It has two purposes: (1) to protect the public, and (2) to enhance the profession and give its members a monopolistic advantage. That it does the second more effectively than the first is the real flaw in current licensing. The answer, however, is not to throw public protection out with the professional monopoly, but to increase public protection and competition in the health care field simultaneously. The authors are correct that these two goals need not be conflicting.

We do not need licensing because the majority of the population is inherently stupid and cannot understand basic health care concepts. Rather, when one actually needs medical treatment, one is generally suffering from an illness or injury that seriously impairs judgment and drastically limits one's ability to "shop around." It is too late to compare credentials, private certifications, and experience. One needs some way to know that at least some *minimal standards* have been met by a person who holds himself out as able to diagnose and treat. Those minimal standards are assured by licensing. To protect the sick and injured against exploitation by unqualified practitioners, mandatory licensing seems necessary.

On the other hand, to make licensing more responsive to the public, and less responsive to the economic concerns of licensees, some significant changes are certainly in order. Let me suggest a few:

1. Licensing standards should be uniform throughout the country;
2. Licenses should be periodically renewed by re-examination;
3. Licensing boards should be composed exclusively of non-licensees (expertise, when needed, can be supplied by the staff or by expert consultants);
4. Much stronger steps should be taken to identify and discipline (and, if possible, rehabilitate) negligent, incompetent, and disabled physicians;
5. The multiple health licensing boards that presently exist should be consolidated into one board that has jurisdiction over all health care professionals so that the stranglehold that medicine now has over all other health professions can be loosened, making more qualified practitioners available to the public.

Dr. Steven Jonas has argued that, "Licensing laws as now written . . . exist very much to meet the needs of the licensed profession and not very much to meet the needs of society. If social needs are to be met, what makes sense is to list all the health care delivery tasks that need to be done and divide them into groups such that one person can reasonably acquire the knowledge and skills needed to carry out each group well."[1] This "rational task analysis" has much to offer, and can only be accomplished by a unified health board.

Anti-regulation arguments are running wild, and have now reached the health care field. No one likes governmental regulation; but for most of us, a society without it would be too dangerous to our health.

References

1. JONAS, S., MEDICAL MYSTERY: THE TRAINING OF DOCTORS IN THE UNITED STATES, (W.W. Norton, New York) (1978) at 333.

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Tort Liability of Nursing Homes for Involuntary Transfer of Patients, for First Prize in the 1980 John P. Rattigan Memorial Essay Competition. The $300 is greatly appreciated and, as I am sure you know, will be helpful in meeting my educational expenses. I enjoyed researching and writing the paper and being awarded First Prize was truly "icing on the cake."

Again, my sincerest thanks.

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Allocating Responsibility by Contract

Dear Editors:

Society is currently experiencing a historic transition in the way it addresses questions of responsibility for health. Constitutional rights and doctrines of informed consent offer the basis for change, but individuals, "physicians" and their advisors must take the initiative to clarify the confusion which accompanies any change. Six years ago, my studies of malpractice cases revealed recurrent misunderstandings about the role of "physicians" and I wondered if the medical role could not be clarified by encouraging the definition of individual and professional responsibility by express agreement.

Although the doctor-patient relationship is fundamentally contractual in nature, questions of professional responsibility have always been litigated as torts. Courts have "implied" a contract when questions of fees arise, and we are now grappling with "informed consent," a contract principle which has evolved as a tort defense. I suggest that our difficulties with this doctrine and many other issues may be relieved by addressing the contractual nature of the relationship *expressly*.

The recent ASLM conference in Los Angeles on the *Legal and Ethical Aspects of Treatment for Critically and Terminally Ill Patients* raised fundamental questions about quality of life *choices*, that, I submit, need not be decided according to criminal law principles embodied in murder statutes. If *choice* is the real issue, then *contract* is the appropriate context for our thinking. The conference also demonstrated the frustration experienced by health professionals in seeking "informed consent" without any way of knowing what the patient actually understands. If this doctrine represents a judicial stepping stone from tort to contract, we have in the latter the opportunity to examine the patient's goals and expectations in the relationship. Courts will modify the doctrine to suit the needs that are discovered in the process.

University of Chicago Professor Richard Epstein has laid the foundation for judicial recognition of contracts in two scholarly articles which recall our natural evolution in other fields from tort to contract as we learn how to allocate risks previously litigated according to principles of common law negligence.[1] Epstein suggests that contract thinking is not only a good idea now, but that it is historically inevitable.

Another confirmation of the contractual nature of health care relationships is the arbitration agreement, which merely shifts the forum for resolving disputes. It does little to shed light on the kind of agreements that are necessary to make the doctor-patient relationship work, and may promote controversy by focusing initial attention on the anticipation of failure. If arbitration agreements make any sense at all, they suggest to me that even greater productivity might come from exploring the functional responsibilities of doctor and patient.

Rogers v. Okin,[2] discussed in the April 1980 issue of MEDICOLEGAL NEWS in an article by Dr. Daryl Matthews, may represent the latest step in judicial concern for freedom of choice in medical care. It suggests that the First Amendment, in addition to the right of privacy, may apply to one's choice of medical treatment. If our job is to evaluate the allocation of choices, contract is a more appropriate context than tort or criminal law.

My experience conducting seminars for health professionals suggests that the main problem is clarifying the relationship between patient responsibility and medical responsibility. The popular banner of individual responsibility has not begun to be defined. Doctors can limit professional liability by discussing their roles in terms of diagnosing and treating pathology and defining patient responsibility in terms of the dynamics of health that are within individual control. We need not view this as a contract that needs to be written by lawyers. Physicians and patients should be encouraged to make a plan, which identifies a purpose, complementary responsibilities, and a term. A verbal agreement is the result of a process of contracting, and may be evidenced by the conduct of the parties, notes, memoranda, or letters.

Furthermore, Epstein suggests that once we make this shift in context, we can explore contractual limitations of damages, and even consider limiting liability to gross negligence, which I believe might be defined with greater precision by a progressive medical profession.

As an Advisor to the San Francisco Consortium Collaborative Health Program, a federally funded study of the allocation of responsibility between doctors, nurses, and consumers, I have observed the evolution of a model for contracting. The study examines the behaviors and attitudes which are conducive to collaboration and those which are barriers to making meaningful agreements, which is the object of collaboration. This pioneering work offers physicians the opportunity to develop a plan for implementing a definition of their roles and responsibilities in accord with that which their science prepares them to assume.

The precedence which our legal system gives to private agreements over common law principles gives doctors an alternative to judicially defined standards of practice. Physicians should establish seminars for structuring relationships by contract, develop a plan for clarifying the nature of their own professional responsibilities, and encourage public education about the dynamics of health that are within individual control.

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References

1. *Contracting Out of the Medical Malpractice Crisis*, PERSPECTIVES IN BIOLOGY AND MEDICINE, Winter 1977 at p. 228; *Medical Malpractice: The Case for Contract*, AMERICAN BAR FOUNDATION RESEARCH JOURNAL *1976(1)*: 87-149.

2. *Rogers v. Okin*, 478 F. Supp. 1342 (D.Ma. 1979).

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