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Licensing Health Care Professionals: Has the United States Outlived the Need for Medical Licensure?

GREGORY DOLIN*

> I am myself persuaded that licensure has reduced both the quantity and quality of medical practice . . . . It has forced the public to pay more for less satisfactory medical service.[1]

> [T]he only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not sufficient warrant.[2]

> No man is an island, entire of itself; every man is a piece of the continent, a part of the main. If a clod be washed away by the sea, Europe is the less, as well as if a promontory were, as well as if a manor of thy friend's or of thine own were: any man's death diminishes me, because I am involved in mankind, and therefore never send to know for whom the bell tolls; it tolls for thee.[3]

I. INTRODUCTION

These quotations illustrate the major strains of thought that have governed regulation of American medicine over the last 400 years. With an expanding market for what is now known as "complimentary and alternative" medicine (CAM), states are increasingly facing the issue of who can and who should be allowed to practice medicine. Of necessity, this question also concerns whom patients may see to treat their ailments.

This paper will argue that the struggle to define who is and who is not licensed to practice medicine is rather fruitless and will always leave patients with less choice than they desire. Part II will review the history of licensure in

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* B.A. 1998 Johns Hopkins University; J.D. candidate 2004 Georgetown University Law Center; M.D. candidate 2005 State University of New York at Stony Brook School of Medicine. I dedicate this Note to my parents, Yuri & Natalia Dolin, who made it possible for me to achieve everything I have achieved. Their love and support is a constant source of inspiration. A special thanks to my brother and sister, Ilya and Kayla Dolin, who entertain, support, and love me, and generally make my life more exciting and amusing. Much thanks goes out to my friends both in and out of law school for helping me make it through it. Last, but certainly not least, I thank my professors, Sherman Cohn, Jonathan Missner, and Peter Cohen, M.D., whose help and suggestions on this paper proved invaluable.

1. MILTON FRIEDMAN, CAPITALISM AND FREEDOM (1962) *reprinted in part in* FREEDOM DAILY (Jan. 1994), *at* http://www.fff.org/freedom/0194e.asp (last visited November 29, 2002).

2. JOHN STUART MILL, ON LIBERTY (1859), *excerpts reprinted in* PHILOSOPHICAL PROBLEMS IN THE LAW 162 (David M. Adams ed., 2d ed. 1996).

3. JOHN DONNE, DEVOTIONS UPON EMERGENT OCCASIONS (1623), XVII: NUNC LENTO SONITU DICUNT, MORIERIS.

the United States. Parts III and IV will focus on benefits and problems of restrictive modes of licensure prevalent in most states, respectively. Part V will briefly outline recent developments in CAM. Part VI will develop and critique several alternatives to restrictive licensure, and Part VII will briefly touch on how informed consent plays into the potential change in accreditation that this paper proposes.

II. HISTORY OF LICENSURE IN THE UNITED STATES

At common law, anyone who desired to practice medicine could do so.[4] However, the American colonies started to regulate the practice of medicine as early as 1639.[5] A Virginia statute passed that year governed certain aspects of healthcare such as fees and quarantines.[6] This statute, along with similar ones in Massachusetts (1649), New Jersey (1665), and New York (1665), was enacted primarily for the purpose of controlling excessive health care costs, rather than to truly regulate professional activity.[7] In 1760, New York City became the first U.S. jurisdiction to actually ban unlicensed practice of medicine.[8] Many other cities and states soon followed suit.[9] By 1830, only Pennsylvania, North Carolina, and Virginia[10] did not have statutes requiring governmental licensure or authorizing state examining boards.[11]

Just as quickly as licensing schemes started to spring up, they started to deteriorate,[12] so that by the mid-1800s most of the licensure laws were repealed.[13] The reasons for deterioration of the licensure system were several,[14] and the political leanings of the time figured prominently among them.[15] In the

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4. MICHAEL H. COHEN, COMPLIMENTARY & ALTERNATIVE MEDICINE: LEGAL BOUNDARIES AND REGULATORY PERSPECTIVES 15 (1998).

5. Sue. A. Blevins, *The Medical Monopoly: Protecting Consumers or Limiting Competition*, CATO INSTITUTE POLICY ANALYSIS No. 246, 6 (1995), *at* http://www.cato.org/pubs/pas/pa-246.html (last visited Nov. 29, 2002); Glenn Bradford & David Meyers, *The Legal and Regulatory Climate in the State of Missouri for Complimentary and Alternative Medicine: Honest Disagreement Among Competent Physicians or Medical McCarthyism?*, 70 UMKC L. REV. 55, 60 (2001).

6. *See* Blevins, *supra* note 5, at 60.

7. Mitch Altschuler, *The Dental Healthcare Professional Nonresident Licensing Act: Will It Effectuate the Final Decay of State Discrimination Against Out-of-State Dentists?*, 26 RUTGERS L. J. 187, 192 n.24 (1994).

8. *See* Bradford & Meyers, *supra* note 5, at 60-61.

9. *See* Blevins, *supra* note 5.

10. WhileVirginia did have a licensure statute on the books, it dealt mostly with controlling excessive health care costs, not with mandating exams to assure professional quality. The statute was enacted upon complaints of slave owners who believed they were being overcharged for treatment of their slaves and merely allowed legal action for overcharges. *See* ROBERT DERBYSHIRE, MEDICAL LICENSURE AND DISCIPLINE IN THE UNITED STATES 2-3 (1969).

11. *See* Altschuler, *supra* note 7, at 192 n. 25.

12. *See* DERBYSHIRE, *supra* note 10, at 6; Michael H. Cohen, *A Fixed Star in Healthcare Reform: The Emerging Paradigm of Holistic Healing*, 27 ARIZ. ST. L. J. 79, 121 (1995).

13. *See* COHEN, *supra* note 4, at 16; Bradford & Meyers, *supra* note 5, at 61; Cohen, *supra* note 12, at 121.

14. *See* Altschuler, *supra* note 7, at 192.

15. *See* Blevins, *supra* note 5; Bradford & Meyers, *supra* note 5, at 61.

mid-1800s the country was in the midst of "Jacksonian democracy." Freedom to practice one's chosen profession, together with the freedom to choose one's own healer without interference from the state, was part and parcel of this new political and social climate.[16]

Additionally, at the time, the *diploma*, as opposed to a *license*, was viewed by the public as the true testament to physician's ability.[17] Licenses were viewed as tools for the economic protection of those holding them.[18] Because diplomas were seen to be the measure of qualification, many medical schools were opened and physicians were churned out without much regard for the actual knowledge acquired, either prior to entering the school or during the course of studies.[19] In fact, by 1910, when Abraham Flexner published his now famous report,[20] the U.S. had 148 medical schools, with 22,208 students enrolled.[21] This number of medical students was trained to serve a country with a population of fewer than one hundred million people.[22] By contrast, today the U.S. population has reached two hundred eighty million,[23] but the country maintains only 125 allopathic medical schools with a total enrollment of just over 66,000.[24] Although the proportion of medical students to the population has not changed, the advances in medical sciences over the last century necessitate more physicians, and thus medical students, per person.[25] Therefore, if the number of medical students in the U.S. actually corresponds to the needs of the country today,[26] it

16. *See* Bradford & Meyers, *supra* note 5, at 61; Cohen, *supra* note 12, at 121; Altschuler, *supra* note 7, at 192.

17. *See* Altschuler, *supra* note 7, at 192; DERBYRSHIRE, *supra* note 10, at 6.

18. Altschuler, *supra* note 7, at 192.

19. *See* DERBYNSHIRE, *supra* note 10, at 6.

20. ABRAHAM FLEXNER, MEDICAL EDUCATION IN THE UNITED STATES AND CANADA: A REPORT TO THE CARNEGIE FOUNDATION FOR THE ADVANCEMENT OF TEACHING (1910), *available at* http://www.carnegiefoundation.org/eLibrary/docs/flexner_report.pdf (last visited Nov. 29, 2002) (hereinafter FLEXNER REPORT).

21. *Id.* at 354.

22. 1910 U.S. CENSUS, *available at* http://eire.census.gov/popest/archives/state/stts/st1019ts.txt (last visited Nov. 29, 2002).

23. 2000 U.S. CENSUS, *available at* http://www.census.gov/main/www/cen2000.html (last visited Nov. 29, 2002).

24. *See* ABOUT THE AAMC, *at* http://www.aamc.org/about/start.htm (last visited Nov. 29, 2002). There are also nineteen osteopathic medical schools conferring a D.O. degree, with a total enrollment of almost 11,000. ALLEN M. SINGER, 2001 ANNUAL REPORT ON OSTEOPATHIC MEDICAL EDUCATION 20, *available at* http://www.aacom.org/data/annualreport/annualreport2001.pdf (last visited Nov. 29, 2002).

25. For example, in the field of Radiology more specialists became needed with the invention of the Computer Assisted Tomography (CAT) Scan (1972), Magnetic Resonance Imaging (MRI) (1967), Ultrasound (1956), and Nuclear Medicine (1946). *See* Douglas Amerasekera, *History of Radiology*, *at* http://www.amerasekera924.freeserve.co.uk/history.html (last visited Nov. 29, 2002, on file with the Georgetown Journal of Law and Public Policy). The same can be said about other fields of practice. For example, the specialty of Allergy and Immunology did not exist as a separate entity until 1971. *See* WELCOME TO THE ABAI INFORMATION PAGE, *at* http://www.abai.org (last visited Nov. 29, 2002). And, the specialty of Medical Genetics did not exist until 1980. *See* WELCOME TO THE AMERICAN BOARD OF MEDICAL GENETICS WEBSITE, *at* http://www.abmg.org (last visited Nov. 29, 2002).

26. Evidence suggests that the number of U.S. medical students might be insufficient to meet U.S. needs. The U.S. Government issues J-1 visas to foreign-trained medical graduates to train in the U.S. and allows these physicians to waive a two-year foreign residence requirement if they agree to work in

follows that the number of medical students in the early twentieth century far exceeded the needs of the country.

As medical schools proliferated in the late nineteenth and early twentieth century, the practice of medicine came into disrepute.[27] The American Medical Association (AMA) was formed in 1846[28] with the goal to improve the medical profession and medical education, as evidenced by one of AMA's very first acts: setting minimal standards for medical education.[29] Further, in order to save the medical profession from the continued decline in terms of public trust and respect, the AMA, along with other health profession societies, actively began to seek government involvement and regulation of its professionals.[30] Although the AMA and constituent state medical societies sought to establish minimal requirements and state regulation as early as the mid-1800's (exactly the same time that licensure statutes were repealed),[31] they were not very successful until the early part of the twentieth century.[32] The few statutes enacted prior to the beginning of the twentieth century were neither very exacting,[33] nor uniform across the states.[34] On the upside, these early statutes did withstand constitutional challenge.[35]

The biggest boost in the cause for standard medical licensure came from the Carnegie Foundation, which sponsored a report in 1910 on medical education in the U.S. and Canada.[36] The Flexner Report, as it became known, was scathing toward the for-profit, standardless system of medical education prevalent in the country at that time.[37] The reaction was swift. Rather than relying on medical school diplomas as evidence of certification, over thirty-nine states created state examining boards to license physicians.[38] In 1913, the Federation of State Medical Boards was formed,[39] which subsequently standardized licensure procedures throughout the United States. As a result of the Flexner Report, the number of medical schools was drastically reduced and curricula standardized.[40] In 1915, the National Board of Medical Examiners (NBME) was cre-

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an underserved area. *See* 8 U.S.C. § 1182 (2003). These programs suggest that the U.S. government views the supply of U.S. trained medical students as insufficient for the needs of this country.

27. *See* COHEN, *supra* note 4, at 17.

28. ILLUSTRATED HIGHLIGHTS OF AMA HISTORY, *at* http://www.ama-assn.org/ama/pub/category/1916.html (last visited Nov. 29, 2002).

29. *Id.*

30. *See* Altschuler, *supra* note 7, at 193.

31. *See* Blevins, *supra* note 5.

32. *See* Altschuler, *supra* note 7, at 193.

33. *See* State v. Dent, 25 W. Va. 1, 2-3 (1884) (listing requirements for a West Virginia medical license).

34. *See* Altschuler, *supra* note 7, at 193.

35. *See, e.g.*, Dent v. West Virginia, 129 U.S. 114 (1889), *aff'g*, 25 W. Va. 1 (1884).

36. FLEXNER REPORT, *supra* note 19.

37. *Id.*

38. *See* Altschuler, *supra* note 7, at 193.

39. DERBYSHIRE, *supra* note 10, at 48.

40. Altschuler, *supra* note 7, at 193.

ated,[41] and a year later the first national competency exam was administered in Washington, D.C.[42] By 1968, almost all states recognized the passage of a battery of exams administered by the NBME[43] as sufficient evidence of a physician's competence to practice medicine.[44]

Standardization of physician licensing procedures continued in the late twentieth century. In 1994, several separate licensure examinations—including the National Boards (administered to U.S. graduates), the Foreign Medical Graduate Exam in Medical Sciences (administered to foreign-trained physicians wishing to practice in the U.S.) and the Federation Licensing Exam (an alternative to the National Boards, administered by state licensing authorities)—were replaced by the United States Medical Licensing Examination (USMLE).[45] The USMLE consists of three steps and is now required for licensure in all states.[46]

In order to be eligible to sit for the USMLE exam (and thus be eligible for licensure), one needs to have graduated from a Liaison Committee on Medical Education (LCME) accredited medical school.[47] Additionally, depending on the state, licensure requires completion of anywhere from one to three years of infra-graduate medical training ("residency") in a program approved by the Accreditation Council for Graduate Medical Education (ACGME).[48]

The LCME, the NBME, and the ACGME are private organizations, and neither state nor federal governments review the standards they set. Just as the American Bar Association makes decisions about law school accreditation that are immune from judicial challenge,[49] the LCME makes decisions about medical school accreditation,[50] and the ACGME makes decisions about residency programs.[51] The NBME is also a private organization, and while states are not obligated to accept the results of the NBME administered exams, *all* do. The

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41. *Id.*

42. *Id.*

43. Upon successful passage of the National Boards Parts I, II, & III (all exams administered by the NBME), the status of NBME Diplomate was conferred upon the physician. It is this status that was recognized in virtually all jurisdictions as sufficient for licensure. To sit for these exams, one had to have graduated from an accredited medical school. A year of post-graduate training was also required.

44. Altschuler, *supra* note 7, at 193.

45. *See* WELCOME TO FSMB Online, *at* http://www.fsmb.org (last visited Nov. 18, 2003).

46. *Id.*

47. The LCME is a joint venture between the AMA and the American Association of Medical Colleges (AAMC) that formally accredits allopathic medical schools. The LCME has 17 members, of which 15 hold M.D. degrees, two are students at an allopathic medical school (one appointed through the AMA and one through the AAMC), and two are public members. *See* LCME MEMBERS 2003, *at* http://www.lcme.org/members.htm (last visited Nov. 18, 2003). Although foreign medical graduates also take the USMLE, they must go through a somewhat different process. They must have their credentials verified by the Educational Commission on Foreign Medical Graduates, and they also must take a Clinical Skills Assessment Exam not currently required of the U.S. medical graduates. *See* ECFMG CERTIFICATION, *at* http://www.ecfmg.org/2003ib/ibcert.html#requirementsforcert (last visited Nov. 18, 2003).

48. *See* ACCREDITATION COUNCIL ON GRADUATE MEDICAL EDUCATION HOMEPAGE, *at* http://www.acgme.org (last visited Nov. 18, 2003).

49. *See* Mass. Sch. of Law v. Am. Bar Ass'n., 107 F.3d 1026 (3d Cir. 1997).

50. *See* http://www.lcme.org/overview.htm (last visited Dec. 24, 2003).

51. *See* http://www.acgme.org (last visited Dec. 24, 2003).

states have effectively ceded control over their licensure requirements to a group of allopathic physicians.[52] This development is particularly alarming because licensure, originally designed as a means of preventing fraud and quackery,[53] is now dominated by a particular school of medical thought that often refuses to entertain the notion that nontraditional treatments are a valid and useful means of treating certain diseases.[54]

III. BENEFITS OF RESTRICTIVE LICENSURE

Increased regulation of medical practice and standardization of medical curricula resulted in several significant benefits. First, of course, was elimination of quackery.[55] At the time of the re-emergence of medical licensure laws, medicine was held in very low esteem; even physicians acknowledged that few among them possessed the requisite ability or skill to practice properly. "Quacks abound like locust in Egypt,"[56] was an observation of a contemporary. As a result of the AMA's efforts to improve standards of medical education and Flexner's report, many schools of dubious quality closed.[57] States refused to license or recognize physicians who graduated from a school that did not receive the AMA's seal of approval.[58] The AMA's seal was not easy to get, as evidenced by the fact that between 1904 and 1915 almost 100 medical schools were either closed or merged with more reputable institutions.[59]

With elimination of sub-par medical schools, the standards of medical education and the standards of medical practice rose.[60] Undoubtedly, having skilled practitioners in the practice of medicine serves an important societal goal of protecting the most vulnerable from charlatans and quackery. Thus, assurance of minimum qualification required to obtain a license to practice medicine serves the public by protecting it from dubious and ineffective therapies.[61] The result is that disease, when detected, is treated appropriately, necessarily increasing chances of cure.

In addition to benefiting individual patients, licensure protects the general public. By ensuring that sick people get treated in an acceptable and qualified

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52. Out of thirty members of the AAMC executive council, twenty-two hold an M.D., two are medical students at allopathic medical schools, and others are representatives of allopathic hospitals. Out of twenty-six ACGME directors, nineteen hold an M.D., and out of the remaining seven, two hold seats through the AAMC and two through the American Hospital Association. *See* http://www.lcme.org/overview.htm; http://www.acgme.org.

53. *See* Altschuler, *supra* note 7, at 193.

54. *See generally* Blevins, *supra* note 5.

55. *See* FRANK P. GRAD & NOELIA MARTI, PHYSICIANS' LICENSURE & DISCIPLINE 55 (1979).

56. Cohen, *supra* note 12, at 122.

57. *Id.* at 127.

58. *See* Dent v. West Virginia, 129 U.S. 114 (1889).

59. *See* Cohen, *supra* note 12, at 127.

60. *See* GRAD & MARTI, *supra* note 55, at 60-61 (listing stringent requirements for licensure in several states).

61. For a full discussion of prevalence of quack therapies, *see generally* JAMES H. YOUNG, THE MEDICAL MESSIAHS: A SOCIAL HISTORY OF HEALTH QUACKERY IN TWENTIETH-CENTURY AMERICA (1967).

manner, the state ensures that the spread of contagious or infectious disease is contained and that a smaller percentage of the population is exposed to such disease.[62] Additionally, licensure requirements protect financial resources by preventing expenditures on ineffective remedies that are pushed by unqualified practitioners, as well as expenditures on such practitioners themselves.[63] It is axiomatic that, if one is prevented from seeing an unqualified physician, one does not pay such a physician, and therefore does not expend money for that purpose.

Finally, licensure has brought about improvements in education. Faced with the requirements of appropriate coursework and medical training, medical schools had to hire better faculty to teach and examine their students rigorously.[64] In turn, students could no longer expect to practice medicine simply by having spent a number of years in a medical school without receiving appropriate medical training. Requirements in several states that mandate continued medical education as a pre-requisite for renewal of licensure further increase physician competence by forcing physicians to keep abreast of current developments in the medical sciences.[65] Just as initial licensure depended on education (or poor quality thereof), now education (or rather the maintenance of high standards therein) in large part depends on licensure.[66]

Maintenance of the quality of care is also achieved by licensure. As stated in Part II, licensing authorities depend heavily on private accrediting agencies. Because these agencies have an interest in protecting their exclusive status in the system, they go after violators aggressively and make sure that standards are maintained, lest public outcry cause a wholesale reevaluation of this system of self-regulation.[67] For the same reason, the accrediting and evaluative agencies will exact a high a price on potential entrants into the market, requiring them to adhere to the same minimal standards that are considered necessary for the adequate practice of medicine.[68]

Several important goals are thus achieved by the restrictive state licensure of physicians. First, licensure eliminates quackery, which protects unsuspecting and vulnerable patients from those who instead of treating the ailment will make things worse, either through their unskilled intervention or delaying the qualified help of a physician. Second, the public health is protected from the spread of infection as a result of failure to treat a condition (this effect is a

62. CAROLYN COX & SUSAN FOSTER, BUREAU OF ECONOMICS FEDERAL TRADE COMMISSION, THE COSTS AND BENEFITS OF OCCUPATIONAL REGULATION 10 (1990) (hereinafter FTC REPORT).

63. *See id.* at 5 (describing "market failure" and "asymmetric information on quality" as an impetus behind occupational licensing).

64. *See* DERBYSHIRE, *supra* note 10, at 11 ("Now . . . relatively high standards are maintained in most schools.").

65. GRAD & MARTI, *supra* note 55, at 71-81.

66. *See* Bradford & Meyers, *supra* note 5, at 62-63.

67. *See* William T. Gallagher, Ideologies of Professionalism and the Politics of Self-Regulation in the California State Bar, 22 PEPP. L. REV. 485, 497 (1995).

68. *See id.* at 488 n.2.

corollary of the first). Third, licensure advances the goals of science by making sure that practitioners enter the market with sufficient knowledge and keep abreast of subsequent developments in their field. Finally, licensure saves people money by preventing disreputable practitioners from fleecing patients. However, this last point is open to debate, as we shall see in Part IV.

IV. PROBLEMS OF RESTRICTIVE LICENSURE

Just as there are benefits to restrictive licensure, there are problems, which are often the flip side of the benefits obtained. In the final analysis, one needs to decide whether the benefits obtained outweigh the problems created, and whether a different regime may be able to maximize the benefits while minimizing problems. This paper argues that the problems created by licensure outweigh the benefits and that a different system, discussed in Part VI, will be better suited to today's medical landscape.

Foremost among the problems associated with the fact that licensure is dominated by the allopathic profession is the most obvious: the exclusion (or attempted exclusion) of all non-allopathic professionals from the field.[69] For example, in addition to closing down almost 100 medical schools as a result of Flexner Report, allopathic medical practitioners prevailed over homeopaths[70] and, in essence, forced conversion of three remaining reputable homeopathic schools into "regular" allopathic ones.[71] Allopathic dominated state licensure boards steadfastly and adamantly refused to recognize or license homeopaths.[72] Homeopaths were expelled from all medical societies[73] and, because their schools did not receive the AMA endorsement, could not be licensed.[74] The situation was so bad that courts, in spite of the fact that the state's right to regulate the practice of medicine was not seriously disputed, have on occasion held that the board acted arbitrarily and capriciously in failing to grant licenses to non-allopathic practitioners.[75]

The stamping out of non-allopaths did not stop with the victory over homeopaths. The AMA and its constituent state and county societies refused to admit members who were trained at accredited and reputable schools of osteopathy.[76] The whole study of osteopathy was derided as "idiocy."[77] Refusal to admit osteopathic physicians to medical societies effectively barred them from practicing medicine, as hospitals would extend practicing privileges only to those

69. *See* Blevins, *supra* note 5; Bradford & Meyers, *supra* note 5, at 62-63; COHEN, *supra* note 4, at 19.
70. COHEN, *supra* note 4, at 19-20.
71. *Id.* at 20.
72. *See* Bradford & Meyers, *supra* note 5, at 62.
73. *See* COHEN, *supra* note 4, at 18-19.
74. *See* Bradford & Meyers, *supra* note 5, at 62-63.
75. *See, e.g.*, McCleary v. Adcock, 105 S.W. 270, 271-72 (Mo. 1907).
76. *See, e.g.*, Falcone v. Middlesex County Med. Soc'y, 170 A.2d 791, 792-94 (N.J. 1961).
77. *Quackery in America*, 283 JAMA 1978 (2000).

physicians who were members of the local medical society.[78] Although membership in a local society (and hospital privileges) and a state license are two distinct things, the people who ran the societies were either the very same people who sat on licensing boards[79] or who lobbied licensing boards to keep licensure exclusive to those with an M.D. degree from an AMA-approved school.[80] In fact, osteopaths did not achieve licensure throughout the country until 1974,[81] even though it was clear significantly earlier that their services were no worse than those of allopaths.[82]

Chiropractors suffered much the same fate at the hands of the AMA and established medicine. The AMA held chiropractors to be quacks, and the AMA Code of Ethics held any dealings with chiropractors to be unethical.[83] Again, although it has become increasingly clear that chiropractics is valuable for some purposes,[84] to this day, the AMA attempts to limit what chiropractors can do.[85] In this relentless march to stamp out competition, the AMA undoubtedly lost the opportunity to discover, and let the public discover, whatever benefits alternative healing professions have to offer. Furthermore, the field of potential healthcare providers has been kept low (or lower than the market would allow) and this (at least in part) is responsible for lack of access to medical services among certain segments of society.[86] Obviously, the examples above are not exhaustive, but they are indicative of the kind of exclusionary practices in the restrictive licensure regime.

The medical profession was not content, however, with simply eliminating the competition. The licensing and disciplinary boards to this day take disciplinary action, including license suspension and revocations, against those *allopathic* providers who deviate from what mainstream medicine deems to be acceptable medical care.[87] The authorities act against these non-compliant allopaths even when there are no complaints from patients,[88] and even when patients will do whatever it takes to see a particular physician. A physician who wishes to truly tailor treatment to his patient and who wishes to exercise his own best judgment with respect to a given patient is threatened with a loss of

78. *See Falcone*, 170 A.2d 791, 794 (N.J. 1961).

79. *See* GRAD & MARTI, *supra* note 55, at 57-59.

80. *Id.* at 58-59.

81. OSTEOPATHIC MEDICINE HISTORICAL TIMELINE, *at* http://www.studentdoctor.net/do/timeline.asp. (last visited Nov. 19, 2003).

82. For example, as early as 1963, D.O.s were accepted as legitimate medical officers by the Civil Service. In 1966, the Pentagon accepted D.O.s as military medical officers on a volunteer basis, and a year later extended the "medical" draft to include D.O.s. *Id.*

83. *See* Blevins, *supra* note 5.

84. *See* Wilk v. Am. Med. Ass'n., 671 F. Supp. 1465, 1471 (N. D. Ill. 1987) (referencing a report prepared by the New Zealand government on chiropractic medicine in 1979).

85. Blevins, *supra* note 5.

86. *Id.*

87. *See, e.g.*, Bd. of Med. Exam'rs v. Burzynski, 917 S.W. 2d 365 (Tex. App. 1996); Gonzalez v. Dep't of Health, 648 N.Y.S.2d 827 (N.Y. App. Div. 1996); *see also* FLETCHER, POLITICS OF MEDICINE: THE STRUGGLE FOR FREEDOM OF MEDICAL CHOICE, ALTERNATIVE MEDICINE 86 (2001).

88. *See* FLETCHER, *supra* note 87.

license and consequently loss of livelihood.[89] The patient in turn faces a loss of the healthcare provider whom he prefers to others. Not only does this punitive and oftentimes vindictive prosecution of physicians lead to diminished choices among healthy people when it comes to controlling and maintaining their own health, it often cuts off hope of those who have nothing else to hope for.[90] As the Supreme Court has held in *United States v. Rutherford,*[91] that there are no exemptions from the Food, Drug and Cosmetics Act (FDCA) for the terminally ill, so too have medical boards refused to allow novel, unorthodox, or experimental (in other words "alternative") treatment for terminally ill patients.[92]

The biggest problem for advocates of licensure is that the listed objections are not exhaustive. The most damning objection to licensure is that it fails on its own terms. The main pillars of the licensing scheme are the reduction in unnecessary expenditures and improvement in the quality of care delivered to patients. Both of these were discussed in Part III. However, as indicated in that discussion, even these mainstay defenses are not beyond dispute.

Although it can be argued that the licensure scheme saves patients money by preventing expenditures on quacks and quackery, it does not follow that the *overall* level of spending in a licensure regime is lower than that in a more liberal regime. The problem with licensure is that it creates entry barriers to competitors;[93] thus allowing specialists already in the market to keep prices at levels that are higher than they would have been if entry into the market was easy.[94] The increase in prices not only has the potential to offset the savings engineered by the foreclosure of the quack market, but, more ominously, it can price some people out of the market completely. This result is well illustrated by the failures of our healthcare system that leave over forty million people uninsured.[95] The lack of access to care results in people either: foregoing care completely or accessing care in a very limited and inconsistent way.[96] Both result in a population that is sicker and, in the long run, more costly to treat. The increase in spending because of barriers to entry and the increase in end costs due to unavailability of care (itself the result of high costs associated with licensure) largely negate one of the main arguments for keeping and increasing the standards required to obtain a license to practice medicine.

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89. *Id.*

90. *See id.*

91. 442 U.S. 544, 555-56 (1979).

92. *See, e.g.,* MO. REV. STAT. § 334.100(4)(f) (2000) (giving the Board of Healing Arts power to discipline any physician for "[p]erforming or prescribing medical services which have been declared by board rule to be of no medical or osteopathic value").

93. *See* FTC REPORT, *supra* note 62, at 28.

94. *Id.*

95. 2000 STATISTICS FOR U.S. HEALTH INSURANCE COVERAGE: DATA FROM THE 2000 MEDICAL EXPENDITURE PANEL SURVEY OF THE AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, *available at* http://www.meps.ahrq.gov/Pubdoc/HI2000Stats.pdf (last visited Nov. 19, 2003).

96. *See* FTC REPORT, *supra* note 62, at 35.

Finally, perhaps the most surprising and at the same time most severe shortcoming of the licensure regime is that no significant quality improvement is achieved by the scheme.[97] This result seems to hold for all spheres of economic activity, not just for the profession of medicine.[98] Indeed, out of the eleven professions surveyed in an FTC Report on the economic cost of professional regulation, only two were deemed to have benefited from licensure or other occupational restriction designed to promote quality, while three were affected detrimentally, with the rest not experiencing any impact.[99]

Not only has licensure been shown to be at least ambiguous with respect to quality assurance, but the calls for constant increase in the standards required to obtain and maintain a license—all in the name of increased quality of care—are disingenuous at best. If without tougher new standards the public is ill-served by incompetent physicians who put their patients at risk, why do these same doctors, who call for an increase in the number of hurdles required for licensing, just as adamantly clamor for "grandfathering" exceptions when such new standards are advanced?[100] If one is supposed to believe the reason advanced by the proponents of more regulation is that these regulations are going to save us from unprofessional and unqualified conduct, *a fortiori* practitioners who do not possess these credentials, yet currently practice, should be deemed dangerously unqualified, and should be required to undertake additional training. Yet, since the days of *Dent v. West Virginia*,[101] the states have "grandfathered" practitioners. The same holds true of accreditation agencies and medical specialty boards.[102] Given these facts, and studies showing at best marginal improvement of quality with the institution of licensure, it is questionable whether quality and public health are indeed the true reasons behind the licensure regime, or whether other less noble considerations are at play.

It seems that whatever effect on quality and conservation of financial resources licensure may have, it is not of the magnitude claimed by its proponents. However, its proponents (notably organized medicine best represented by

97. *Id.* at 27.

98. *Id.* at 26-27.

99. *Id.*

100. *See, e.g.*, Council on Medical Education Report E, A-92, *cited in* AMA POLICY COMPENDIUM, H-405.974, *Specialty Recertification Examinations*.

101. 129 U.S. 114 (1889).

102. Specialty medical boards, unlike licensing boards, are private organizations that issue certificates to specialists and sub-specialists upon completion of the requisite training and passage of required exams. The certificate serves as a "seal of approval" that this particular board deems the individual qualified to practice in a given specialty. The issuance of the certificate has no direct effect on licensure, but is often necessary to obtain admitting privileges in a hospital. Until recently, these boards required the applicant to pass the exam only once in a lifetime and upon passage issued a certificate with no expiration date. Now, most boards issue certificates good for a maximum of ten years and require diplomats to be reexamined in order to renew their certification. However, as mentioned above, most of these boards have "grandfathered" those that were certified prior to these rules (ostensibly designed to improve quality) going into effect. For more information on specialty boards, *see* http://www.abms.org.

the AMA) are adamant in their support for the scheme.[103] That leads one to believe that the real reason lies somewhere else. Regulation often serves to benefit "entrenched groups" and protect them from outside competition.[104] There is hardly a more entrenched group than the AMA and the physicians that it represents. Over the last 100 years, the AMA has successfully pushed the competition out of the market and now zealously guards its territory.[105] Given the fact that over the past twenty years the reimbursement of physicians has dipped,[106] while the out-of-pocket spending on alternative and complimentary medicine has increased,[107] it is unsurprising that physicians are seeking more and more barriers to the new entrants into the market. This is evident even from the treatment of the physicians' own foreign-trained colleagues, who continuously face additional discriminatory qualification requirements in order to obtain a license when compared to the requirements imposed on the U.S. trained doctors.[108] The physicians' opposition to extending the scope of practice of other health professionals is well known and quite virulent.[109] This opposition does not arise out of fear for patient safety but rather from the desire to protect one's own.[110]

Finally, even if we were to put aside the questions of motive, and concede that the balance of benefits and detriments resulting from the system of licensure is more or less even, the conclusion still must be reached that the exclusive and highly restrictive system in place today is counterproductive. This is so because by having a closed system with access permitted only to those trained to think in the ways acceptable to the majority, major discoveries are stifled or delayed. This arrangement breeds close-mindedness that in turn causes rejection of important scientific discoveries and thus retards progress. A prime example is the rejection of the Jenner's smallpox vaccine by the medical community for many years.[111] Yet, this was the discovery that helped bring an end to a disease

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103. *See, e.g.*, AMA POLICY COMPENDIUM H-275.932-933.

104. *Cf.* George Stigler, *The Theory of Economic Regulation*, 2 BELL J. ECON. & MGMT. SCI. 3 (1971) (theorizing that, as a general rule, regulation is designed for the benefit of existing industry).

105. *See* Blevins, *supra* note 5.

106. *See, e.g., AMA Urges Physicians and Patients to Help Fix Medicare Payment Crisis* (Nov. 5, 2002), *available at* http://www.ama-assn.org/ama/pub/article/1751-6739.html (last visited Nov. 29, 2002) (indicating a 5.4% dip in 2002 and an additional 12% dip projected between 2002 and 2005).

107. *See* David M. Eisenberg et al., *Trends in Alternative Medicine Use in the United States, 1990-1997: Results of a Follow-up National Survey*, 280 J. AM. MED. ASS'N 1569 (Nov. 1998); Annemarie Colbin, *New Patients, New Doctors: The Demand for Alternative Treatments and the Changing Face of Medicine*, HEALTHOLOGY (June 25, 2002), *at* http://www.healthology.com/new_patients (last visited Nov. 25, 2002).

108. *See, e.g.*, MD. REGS. CODE tit. 10 § 32.01.03(D) (2000) (requiring foreign trained physicians to have 2 years of post graduate training and U.S. trained physicians to have only one year of same prior to licensure).

109. *See, e.g.*, AMA POLICY COMPENDIUM, H-35.976, *Channeling of Eye Examinations to Optometrists*, (Resolution 213, A-98) (voicing opposition to extending optometrists' scope of practice).

110. *See id.* (emphasizing policy concerns relating to reimbursement rather than patient safety).

111. Indeed, what happened to Jenner is almost identical to the treatment accorded many allopathic physicians today who employ "alternative" treatment methods. Not only were Jenner's initial findings

that had subjected millions to disfigurement or untimely death.[112] Nonetheless, today's medical profession does exactly the same thing to anything that does not neatly fit into its mode of thinking. Indeed, the practice of inoculation came from Chinese (and Indian) medicine,[113] the very same Chinese medicine that is often derided by today's Western physicians.[114] Who knows what other great discoveries are being suppressed by the failure of the licensing regime to permit experimentation in the search for truth.

In brief, the advantages of licensure are not at all clear-cut, while the disadvantages are just as strong if not stronger. Furthermore, the disadvantages are more numerous and may potentially exact an unacceptable cost on society.

V. RECENT DEVELOPMENTS IN COMPLIMENTARY AND ALTERNATIVE MEDICINE

In the last decade this country has seen an explosion in the popularity of alternative therapies.[115] A study in the New England Journal of Medicine asserted that Americans consult alternative providers more than they do their primary care physicians.[116] In 1997, well over half a billion visits were made to an alternative provider by a staggering forty-two percent of Americans. Obviously, Americans see something of value in alternative medicine and are willing to pay for it. Most of these expenditures come out of pocket and add up to billions of dollars.[117] The law, on the other hand, has been extremely slow to catch up with this phenomenon. Most states still have antiquated laws about licensure and the scope of practice that foreclose practice opportunities for alternative healthcare providers.[118]

In response to this growing trend, Congress in 1993 created the Office of Alternative Medicine (OAM) within the National Institutes of Health (NIH).[119] The OAM funded research in the area of CAM and, before being replaced by National Center for Complimentary and Alternative Medicine (NCCAM) in

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rejected as "in variance with established knowledge" and "incredible," but Jenner was warned that "[h]e had better not promulgate such a wild idea if he valued his reputation." Nicolau Barquet & Pere Domingo, *Smallpox: The Triumph over the Most Terrible of the Ministers of Death*, 127 ANNALS OF INTERNAL MED. 635 (1997), *at* http://www.acponline.org/journals/annals/15oct97/smallpox.htm#Note58 (last visited Nov. 25, 2002).

112. *Id.*

113. *Id.*

114. *Cf.* Council on Medical Education Report M, A-93), *cited in* AMA POLICY COMPENDIUM, H-270.974, *Acupuncture* (questioning the safety and efficacy of acupuncture needles).

115. *See* Bradford & Meyers, *supra* note 5, at 64.

116. David M. Eisenberg et al., *Unconventional Therapies in the United States: Prevalence, Costs, and Patterns of Use*, 28 NEW ENG. J. MED. 246 (1993).

117. *See* Colbin, *supra* note 107 (stating that "[t]otal out-of-pocket expenditures for alternative therapies is [sic] estimated to exceed 27 billion dollars, comparable to the figure projected for all out-of-pocket costs for U.S. physician services").

118. *See* Lori B. Andrews, *The Shadow Health Care System: Regulation of Alternative Health Care Providers*, 32 HOUS. L. REV. 1273, 1298 (1996).

119. Kristen J. Josefek, *Alternative Medicine's Roadmap to Mainstream*, 26 AM. J. L. & MED. 295, 296 (2000).

1998, distributed over $13 million in funds.[120] Since the founding of NCCAM, its budget has been increased from $50 million in Fiscal Year 1999 to $113.2 in Fiscal Year 2003.[121] By contrast, OAM was never funded above $20 million, with the initial appropriation being a meager $2 million.[122] The NCCAM not only doles out money for CAM research but also conducts independent research and supports conferences and other events designed to bolster the knowledge about different CAM modalities.[123]

Unfortunately, not all states have taken as progressive a view on CAM. Currently only twenty-one states[124] have any sort of freedom of care statutes or regulations. Thirteen states (these will be referred to as Group I) have regulations or statutes allowing such practice, but *only* by a licensed physician.[125] South Dakota allows EDTA chelation therapy, but not other forms of CAM.[126] Two states allow homeopathic practice, but only to licensed physicians.[127] Florida (Group II) allows access to any alternative therapies from *any* licensed healthcare provider. Finally, only three states, California, Minnesota, and Rhode Island (Group III), allow access to any unlicensed providers and insulate these providers from charges of unlicensed practice of medicine so long as certain conditions are met.[128] For example, a California statute, slated to go into effect on January 1, 2003, still prohibits unlicensed providers from in any way puncturing the skin, administering or prescribing X-rays, prescribing or recommending discontinuation of drugs, setting fractures, or treating abrasions through electrotherapy.[129] A Minnesota statute, the first of its kind enacted, allows the practice of non-traditional medicine, but excludes from that definition surgery, X-ray radiation, administering or dispensing legend drugs and controlled substances, practices that invade the human body by puncture of the skin, setting fractures, and the use of medical devices.[130] Finally, the Rhode Island statute is essentially a copy of the Minnesota statute, with all the limitations of the latter imported.[131]

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120. *Id.*

121. NCCAM FUNDING: APPROPRIATION HISTORY, *at* http://nccam.nih.gov/about/appropriations/index.htm (last visited Nov. 29, 2002).

122. *Id.*

123. ABOUT THE NATIONAL CENTER FOR COMPLEMENTARY AND ALTERNATIVE MEDICINE, *at* http://nccam.nih.gov/about/aboutnccam/index.htm (last visited Nov. 29, 2002).

124. Alaska, Arizona, California, Colorado, Connecticut, Florida, Georgia, Louisiana, Massachusetts, Minnesota, Nevada, New York, North Carolina, Ohio, Oklahoma, Oregon, Rhode Island, South Dakota, Texas, Washington. HEALTH FREEDOM STATES, *available at* http://www.healthlobby.com/statelaw.html (last visited Nov. 29, 2002)

125. Alaska, Colorado, Georgia, Louisiana, Massachusetts, Nevada, New York, North Carolina, Ohio, Oklahoma, Oregon, Texas, Washington. *See id.*

126. Louisiana also allows EDTA, but it allows other alternative therapies as well. *See id.*

127. Arizona and Connecticut. Nevada does the same, but it also allows other alternative therapies as well.

128. *See* MINN. STAT. §§ 146A.01–146A.11 (2000); R.I. GEN. LAWS §§ 23-74-1–23-74-14 (2001); CAL. BUS. & PROF. CODE §§ 2053.5–2053.6 (West 2003).

129. CAL. BUS. & PROF. CODE § 2053.5 (West 2003).

130. MINN. STAT. 146A.01 (2000).

131. R.I. GEN. LAWS § 23-74-1(3) (2001).

Regardless of how one views these statutes and regulations, it is clear that other than chiropractic remedies[132] or acupuncture,[133] over half the states do not allow any sort of alternative medicine practice whatsoever. Some states that technically allow alternative practices by licensed physicians, in fact, go after these physicians when they exercise their best judgment in treating their patients.[134] Most notable among these are New York and Texas.[135] Although technically these states do not set non-conventional treatment as a cause of disciplinary action against licensed physicians,[136] they do in fact prosecute their physicians when they deviate from the "standard of care." New York, for example, uses a requirement for "effective treatment of human disease"[137] to prosecute physicians who provide complimentary care. Texas regulations suggest that complimentary care, while not grounds for adverse action against a physician *per se*, must indeed be *complimentary*, that is to say, in conjunction and not interfering with accepted modes of treatment.[138] These limitations hinder the provision of care according to physicians' best judgments and allow the medical establishment to continue to suppress novel and unorthodox methods of medical care.[139]

Because sanctions for practicing outside the "standard of care" result in a loss or restriction on a physician's license, a physician becomes unable to continue being an alternative-care provider under those statutes that allow only licensed physicians to provide any care (including alternative therapy). Thus, the allopathic-dominated state medical boards in essence make sure that no one provides care that they deem to be non-conventional *in spite of* the statutes and regulations allowing this very same kind of care.[140]

All in all, over the last decade CAM has made significant strides. Mostly these strides have come in the form of increased consumer confidence in CAM, evidenced by the increased spending on various CAM modalities. In terms of funding and research, Congress has also taken a step in the right direction. States, however, have lagged behind, with the exception of California, Minnesota, and Rhode Island. This state of affairs benefits neither patients nor providers of alternative care. By restricting a product widely desired by consumers, states supplant their own conclusions about appropriate care for consumers' choices and judgments about their own health. This interference destroys the doctor-patient relationship and also impedes investigation into new modalities of treatment.

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132. All fifty states and the District of Columbia license chiropractors.
133. Forty-three states and the District of Columbia permit acupuncture.
134. *See* Bd. of Med. Exam'rs v. Burzynski, 917 S.W.2d 365, 368-69 (Tex. App. 1996).
135. *See id*; Gonzalez v. Dep't of Health, 648 N.Y.S.2d 827, 830 (N.Y. App. Div. 1996).
136. *See* HEALTH FREEDOM STATES, *supra* note 124.
137. N.Y. EDUC. LAW § 6527(4) (McKinney 1998).
138. 22 TEX. ADMIN. CODE § 200.3 (West 1998).
139. *See Burzynski*, 917 S.W.2d at 368-69.
140. *See id*; *Gonzalez*, 648 N.Y.S.2d at 830.

VI. ALTERNATIVES TO LICENSURE

Given the problems associated with medical licensure and the scope of practice laws, several alternatives must be explored. One approach, which is likely to be the most palatable to the medical establishment, is the one undertaken by the Group I states.[141] This approach allows physicians to practice non-conventional treatment without fear of losing their license but does not allow anyone who does not hold a valid medical license to practice. Under this approach, all the traditional benefits associated with the licensing scheme remain intact, for only licensed physicians are allowed to practice traditional or non-traditional medicine.[142] This paper has already touched on one problem associated with this approach: boards often either ignore the rules or make them so stringent that no real alternative practice is possible. However, other problems are associated with this method as well.

First, the Group I approach still excludes all other providers and maintains very high barriers to entry into the profession. This in turn leads to all the negative economic effects discussed in Part IV. Thus, the price of services will not go down and millions of Americans will continue to be priced out of the market. One may even theorize that the costs will *increase*, as physicians will provide more services to their patients.

Second, although a license to practice medicine does assure the public that the practitioner has been sufficiently trained in Western medicine (again, leaving aside all the concerns expressed above), it does nothing to assure anyone that the physician is appropriately trained in a particular field of complimentary medicine that he intends to practice. There is no reason to believe that simply because one has been trained to diagnose disease according to an allopathic paradigm and prescribe drugs, one is sufficiently trained to administer acupuncture or prescribe Chinese herbs. Allowing allopathic physicians to practice complimentary medicine that they are untrained in may do more harm than good both to patients and to the cause of CAM. Therefore, although the Group I approach is an improvement over the status quo in most states, it is highly open to abuse by opponents of CAM, woefully inadequate in addressing the shortcoming of the licensing system in general, and potentially detrimental to the advancement of CAM.

The second alternative to licensure is the Group II or Florida approach.[143] Under this approach, *any* licensed healthcare professional may offer alternative or complimentary treatment to the patient. Thus, the practice is not limited to physicians, which, at the very least, addresses some of the concerns regarding barriers to entry and excessive cost. This is because more people can enter the field (one need not be a physician) and because increased competition tends to

141. For classification of groups, *see supra* Part V.

142. This, of course, presupposes that licensure actually has real, tangible, and not just speculative benefits, a concept not wholly foreclosed to debate. *See supra* Parts III-IV.

143. FLA. STAT. ch. 456.41 (2001).

depress prices. It also addresses, at least partially, the concern that practitioners untrained in CAM will be the ones who provide this type of treatment. If providers licensed in alternative disciplines are allowed to provide CAM treatment, it is more likely that the treatment provided will be consistent with the theory underlying the same.

Unfortunately, the way the Florida statute is structured presents two objections to this approach. First, the statute allows *all* licensed healthcare providers to employ any CAM modality in the treatment of patients. By its terms, the statute allows, for example, physical therapists to prescribe Chinese herbs. This raises the same problem presented by the Group I plan. Second, the statute still requires the provider of CAM to be licensed in some area of healthcare. Licensure by its very nature requires fulfillment of certain objective criteria—leaving aside for the moment whether these criteria really measure what they purport to—it is hard to fathom what criteria one would need to fulfill to practice exclusively in the field of, say, aroma therapy or energy healing. These CAM modalities are by definition not open to objective scientific measurement, and their providers can hardly be expected to pass any sort of standardized exam to prove proficiency. Such a requirement would simply be an exercise in futility and absurdity. Consequently, we come to the conclusion that the modalities that are not open to objective examination will either be practiced by people whose primary training lies in other areas or not practiced at all. Neither possibility is gratifying.

The same criticism applies to a modified Group II approach where every conceivable modality would be separately licensed and overseen by its own professional board with limitations on the scope of practice between the separate modalities. Like in a traditional Group II approach, it is nearly impossible to establish objective criteria for some modalities and highly impractical to do so for others. Furthermore, this approach suffers from a major flaw in that it views CAM as a conglomerate of distinct modalities that are not interrelated, when in fact the very heart of the CAM approach is integrative and holistic medicine. Therefore, the Group II approach, either in its traditional or modified form, does not satisfactorily address concerns raised in this article regarding provision and access to CAM.

The next option is the Minnesota or Group III plan. This plan simply exempts unlicensed providers from liability for violating the Medical Practice Act so long as these providers do not cross into the practice of allopathic medicine (*e.g.*, puncturing skin or ordering X-rays). This plan achieves the result by permitting "unlicensed medical practices" (offering a long but non-exhaustive list of modalities). While this approach is the best of those that have been tried in the United States in recent memory, nonetheless, it is not ideal and is open to several criticisms.

The first criticism that can be leveled against this approach is that, while

allowing CAM to be practiced by "unlicensed providers,"[144] it does not exclude *licensed* practitioners from liability for violating their "standard of care" if they choose to offer CAM treatment to their patients. Thus, a physician, even one who is fully trained in a given CAM modality, could be subject to disciplinary proceedings against his license if he chooses to offer this treatment modality in lieu of, or even in conjunction with, conventional treatment. Again, such an approach, by restricting the type of treatment physicians can provide, defeats the purpose of CAM which is to provide holistic care.

The second criticism that can be leveled at this scheme is that it keeps intact many barriers to entry in places that are unnecessary, keeping the prices higher than they would have been in a completely free market. It is unreasonable to think that a CAM provider is unqualified to suture an abrasion while a third-year medical student on his first rotation is. Thus, at least some of the restrictions imposed by the Group III approach are not dictated by health and public safety concerns, but merely by the desire to protect an entrenched group economically.

The first criticism can be partially addressed by mandating that no licensed provider may be subject to disciplinary action simply for engaging in alternative or complimentary treatment. This solution, however, is too easily circumvented by the professional Boards. The second criticism cannot be addressed by this modification of the Group III plan nor is it likely that it can be addressed by any plan other than a radical change in the overall system of licensure.

While the Group III plan is by far the best solution out of all those discussed so far, it still falls short. An even more radical approach is needed. The time has come to scrap licensing system altogether. Two potential substitutes can be instituted instead of licensure. One is certification, and the other registration. The latter option is preferable.

Certification is a process whereby one can enter and practice medicine, but only individuals achieving a certain level of training and expertise are granted a certificate issued by the state attesting to the fact that the state deems them to be qualified. Because market entry would be eased and prices kept at their most competitive level, this system would address the concern about the high costs associated with licensure. Second, as long as the certificate cannot be revoked for anything other than malpractice, the risk of professional boards abusing their power to punish physicians deemed to have deviated from the standard of care is also addressed. This becomes somewhat tricky because malpractice can be defined as "scope of practice" leading us back to the same problem. However, if malpractice, for the purposes of withdrawing certification, is defined only as failure to follow sterility requirements and the like, or failure to obtain a full informed consent from the patient, then this problem can be addressed. Yet, even if the issue of abusive boards cannot be addressed, physicians will have

144. Such providers are defined as the ones who do not hold a license in any medical profession that is overseen by an established professional Board. *See, e.g.*, MINN. STAT. § 146A.01(6) (2000).

less cause to worry, for they will be able to continue practicing in unorthodox ways even in the absence of certification. Finally, certification addresses the issue of who can practice what medicine. Because no one would be banned from practicing medicine prior to obtaining state's permission in the form of a license or a certificate, all healers would be able to practice whatever form of allopathic, osteopathic, chiropractic, or any other form of medicine they desired.

Registration would serve essentially the same goals. The main difference between registration and certification is that under the former, all one needs to do to practice a profession is file his name, address and qualifications with the state. The state makes no judgment as to whether an individual is qualified. Registration achieves all the same results as certification. And, this approach is preferable to certification due to the existence of medical specialty boards. Because these private boards already in effect certify qualified practitioners, there is hardly a need for a duplicative state action. Should these boards cease to exist, or should other boards whose only purpose is to issue certificates on receipt of money proliferate, this position would bear rethinking. At the present stage, however, it is hard to see a need for the state to do the work that is already being done by other well-qualified private agencies. The state may still withdraw registration for violations of safety or health regulation or upon concluding that the patients of a particular healer suffer disproportionately worse outcomes than similar patients in the hands of other healthcare providers. An added benefit is that withdrawal of registration, unlike that of certification, will ban an individual from further practice of medicine. This leaves the state with some measure of control over those who truly harm their patients and public health.

The main objection to the certification or registration regime is that it does not take into account certain externalities. For instance, one with a contagious disease may go to a cheaper but not well-qualified provider or fail to get the appropriate treatment and then spread the disease. To this there are two answers. One, which has already been discussed, is that rigid licensure does not necessarily improve quality of care, and hence lack of licensure is not likely to lower the quality of care. However, leaving this aside, our malpractice system is able to deal with practitioners who misdiagnose or improperly treat their patients. The prospect of being held liable, not only for improperly treating the patient but for causing the spread of infection to others, will be a sufficient deterrent against a slipshod approach to patient care.

All this is not to deny that the State has legitimate reasons to restrict certain practices to a group qualified to perform them if a sufficient showing can be made that without such restrictions serious public harm will ensue. Primarily, the concern lies with prescription drugs. It is undeniable that some drugs that are currently available through prescription are dangerous only if not properly administered. A prime example is thalidomide, a drug that can lead to severe prenatal abnormalities resulting in babies born without one or more limbs. Clearly, making such a drug available for general use without setting any

restrictions would disservice the population. The crucial difference lies in the idea that if an individual wishes to seek treatment from an unqualified professional, that is purely his business, and the choice, if informed, should not be meddled with. If, on the other hand, such a choice *directly* and adversely affects others, the state should restrict such choice.[145]

The final question that arises when either of these approaches is proposed is how to insulate patients from false and misleading claims while at the same time giving them the choice of providers. This is a question of informed consent that will be addressed in the next part of this note.

A certification or registration system would give consumers the greatest choice at the lowest price. If properly crafted and monitored, it does not result in lower standards of care, but does result in increased competition for ideas and greater access to a greater variety of treatment. It also uniquely allows for a truly holistic approach to medical care. For all these reasons, certification or registration is the best replacement of the current restrictive licensure regime.

VII. INFORMED CONSENT

If we are to embark on a radical change in our licensure system, we must keep in mind the reason that restrictive licensure came to being in the first place: the proliferation of quacks and complete lack of public trust in medicine as a profession.[146] Also, one must not forget that healers deal with vulnerable populations open to exploitation.[147] Therefore, completely opening up the market without any sort of restrictions would inevitably lead us right back to where we started, namely, public clamor to regulate and license physicians. We would come full circle and end up facing the very same problems that this note spent a great deal of time addressing. The only way out of this conundrum is for the patients to have a truly informed choice about their care options and to give a truly informed consent.

Informed consent is more than just a bunch of papers a doctor gives a patient to sign right before surgery. Too often, patients who have been given such forms do not read them, nor do patients listen to physician's explanations about risks of the procedures. Thus, such an approach can hardly be termed *informed* consent. For the consent to be truly informed in the brave new world of no licensure that is being proposed here, truthful information needs to start flowing from the very first interaction of the doctor and his patient. What's more, it should start even before the physician patient relationship is formed.

In order for patients not to be deceived, certain practices that are likely to

145. Another prime example of how the state should be allowed to restrict choice when such choice affects others is restricting parental choice of physicians for their children. While the parents may choose to undergo conventional or non-conventional treatment, or for that matter to forgo treatment altogether, they cannot prevent their children from obtaining currently acceptable medical treatment.

146. *See supra* Part II.

147. For a discussion of how medical charlatans prey on the vulnerable, *see generally* YOUNG, *supra* note 61.

mislead must be curtailed. For example, no one should be allowed to use the title "doctor," "physician," or "M.D." unless it is earned at an accredited institution.[148] No one should be allowed to claim that their method cures a disease unless sufficient scientific evidence can be produced to support such a claim.[149] No one should be able to claim that they are specialty board certified unless they are.[150] A provider of medical services (CAM or allopathic) should have to disclose his training (or lack thereof) to a potential patient, as well as the fact that the treatment proposed has no benefits proven by an acceptable scientific method if such is true. The provider, of course, should be allowed to share personal experience regarding the benefits of such treatments despite the admitted lack of acceptable studies supporting the treatment approach. Moreover, the provider should also disclose what theory he relies on in pursuing a given treatment, what the charges are based on, and a reasonable estimation of costs associated with a particular mode of treatment.[151] The Minnesota statute allowing unlicensed providers to practice medicine in a limited way serves as a good starting point toward setting up a comprehensive informed consent regime to supplant a licensing scheme.[152]

In short, if we are to dispense with licensure on the premise that patients should have a free choice in the treatment they pursue, we must make sure that the choice made is indeed a true choice and not colored by untruths and innuendos. Otherwise, the entire premise of informed consent simply fails. Additionally, strict exactions are needed to prevent a slide back into the licensure scheme, an eventuality all the more plausible given the fact that it was almost precisely the same problem that led to the institution of licensure in the first place.

VIII. CONCLUSION

The licensure system in place in almost every state for the last 100 years has initially been a success in eliminating quacks that purposely misled and fleeced the populace. Licensure was, perhaps, the only plausible solution in a society in the past. However, as technology has advanced, allowing for better monitoring of unscrupulous practices, licensing has outlived its usefulness. Today, licensure serves primarily as a protection toll of the economic interests of the licensed group. This causes an increase in prices, often pricing patients out of the market or leaving them unsatisfied with the choices available. Although various approaches to expanding patient choice have been tried, none has adequately addressed the pricing or scope of

148. This requirement is already imposed by the most liberal Group III states. *See, e.g.*, MINN. STAT. § 146A.08(1)(w) (2000).

149. *See, e.g., id.* at § 146A.08(1)(e-f) (2000).

150. *See, e.g., id.*

151. *See, e.g.*, MINN. STAT. § 146A.11 (2000).

152. *Id.*

practice concerns. Under all the approaches that have been advanced so far, physicians can still face disciplinary actions for practicing CAM. Such half-hearted solutions do not fully address the problem and are therefore unsatisfactory. The time has come to rethink the entire licensing paradigm. We should move to a certification or registration system linked to strict requirements of full disclosure and informed consent. This is the only way to address all the concerns raised by the licensure system while at the same time ensuring that patients are not misled or taken advantage of.