

ANALYSIS OF PHYSICIAN LICENSURE PROVISIONS  
CONTAINED IN THE HEALTH SECURITY ACT

by

SANDRA DEFOE DUNN

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Department of Health Care & Epidemiology

The University of British Columbia  
2075 Wesbrook Place  
Vancouver, Canada  
V6T 1W5

Date August 25/80

## ABSTRACT

This study examines the implications of, and health interest groups responses to federally developed national standards for physician licensure, contained in the proposed Health Security Act (HSA). The Act was introduced into the United States Congress in 1975 by Senator Kennedy and Congressman Corman. While the legislation was withdrawn from Congressional consideration in 1979, it was unique, offering a comprehensive range of health services to the public with significant implications for changes in the way health care would be delivered and paid for. The Act's physician licensure provisions were a significant attempt to divest states and health interest groups of their control over health manpower (e.g. determination of minimum competency levels, supply levels, and restrictions on services offered by other health professionals.)

The study critiques the Act's physician licensure provisions in a number of ways: it reviews the past and current structures and processes for determining physician licensure; analyzes the interplay between medical interest groups in assuring quality medical care; details the Act's physician licensure provisions; surveys health interest groups concerning their perceptions on physician licensure and the Act's proposed licensure provisions; and, concludes with reasons why the Act failed as well as alternative approaches it could have taken.

The methods of investigation for the study are several: an extensive literature review; interviews and meetings with officials in Washington D.C. representing private interest groups, representatives from Department of Health, Education & Welfare<sup>1</sup>, the Congress of the United States; and a mailed survey to selected health interest groups.

The conclusions of the study are in keeping with United States historical health legislation trends. The demand for this legislation by health interest groups is negligible since enactment of the Health Security Act would have threatened legislative benefits these groups already possess. Considering the substantial funds and organization behind health interest groups, the Act was doomed from the start. Specifically, even though the survey indicates that most health interest groups support the concept of national standards for licensure, these groups do not perceive a role for the federal government in the determination of those standards.

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Thesis Supervisor

<sup>1</sup>The Department of Health, Education & Welfare was recently renamed the Department of Health & Human Services.

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## INTRODUCTION

In 1977 this study of physician licensure in relationship to the proposed Health Security Act (HSA), was initiated. At that time, the Act was receiving wide review by the media and the medical/health journals because of its universal coverage proviso, comprehensive range of health services, budgetary process and placement of the federal government at the administrative helm.

An intriguing feature of the Act, for this author, was its provisions for the development of national physician licensure standards. If effected, the federal government would significantly influence medical manpower - minimum physician competence, supply and distribution. The federal government would divest the states and professionals of a mechanism for controlling the medical market place.

In view of the Act's potential outcome, the thesis analysis of the above issue was organized as follows. First, medical licensure, its historical roots, current structure and interface with other related medical competence measures were reviewed. Second, the HSA was reviewed to determine its potential difference from the existing licensure structure, to evaluate the effects of these measures, and to determine the reason behind the inclusion of medical licensure provisions in the Act. Third, some interest groups - state boards of medical examiners, public interest group, provider, health

insurance, medical school and consumer groups - were surveyed to determine their views of the current licensure structure and the HSA proposed changes. Finally, the previous thesis sections were integrated to explain the reasons for the failure of the HSA.

Even though the Act has been withdrawn now from Congressional consideration, the thesis analysis has pertinence. It illustrates, among other things, the significant interplay between public bodies and private interest groups, in the outcome of proposed health legislation in the United States.

## CONDUCT OF THE STUDY

Preparation for an analysis of the thesis topic at hand has required employment of several information gathering methods. My thesis advisors have been generous in both patience and in providing great latitude in pursuit of this complex assignment.

### Literature Search

An extensive literature review was accomplished. Since the thesis study required review of more than physician licensure, the literature search was divided into six sub-areas. First, United States health policy and national health insurance issues were reviewed. These readings provided a broad base for assessing the Health Security Act legislation. The second area was professionalism. Licensure developed out of a perception of professionalism. This section delineated the basis for being considered a professional as well as highlighted the self protective stance professionalism engenders. The third area covered considered the economic implications licensure represents for the provider group and medical costs to the public. The fourth area reviewed the function of licensure, the success of licensure as a quality assurance measure, and alternatives to licensure in the quality assurance area. The fifth area considered political influence and reviewed necessary political considerations such as organization of the legislative process, and interest groups' affects on proposed

legislation. These readings helped to detail the ways various interests can work for or against passage of legislation. The final area was international licensure comparisons. This section provided a basis for assessing how similar or different United States licensure practices are to other countries.

### Interviews and Meetings

A number of discussions were held in Washington D.C. with representatives from private interest groups, the Department of Health, Education, and Welfare (HEW) and legislative offices. These discussions were at first exploratory and far ranging but became more sharply focused with a few select individuals.

Discussions were held with representatives from the:

- . American Medical Association;
- . American Public Health Association;
- . Committee for National Health Insurance  
(lobbying arm for Senator Kennedy's National Health Insurance efforts);
- . Health Insurance Association of America;
- . Department of Health, Education and Welfare, Office of Planning and Evaluation (responsible for development of President Carter's national health insurance plan);

- . Department of Health, Education and Welfare, Office of Policy Development and Planning (responsible for the federal government's policy statements on licensure and credentializing);
- . Senator Kennedy's office;
- . House Ways & Means Health Sub-Committee;
- . House Sub-Committee on Health & Environment (Part of Interstate and Foreign Commerce Committee).

### Survey and Analysis

A mailed survey was conducted in early 1979. Different interest groups were queried on their views of physician licensure's methodology and process, and their perceptions of the HSA's proposed physician licensure provisions. Forty-one organizations were surveyed with an overall response rate of 56 percent. The survey contained multiple choice questions with opportunity for responders to write additional comments. The questions were ordered so as to weed out inconsistencies in response; that is, to determine the respondent's view of current physician licensure and acceptable method and process changes before querying him with regards to the HSA's licensure initiatives.

After a follow-up letter was sent, the returned surveys were sorted into the appropriate reference groupings: state medical examiners, public interest groups, provider interest groups, health insurance companies,

medical schools and consumer groups. Responses were tallied and percentages run for each reference grouping and for the full sample.

### Closing Comment

While aware of certain shortcomings in this study, the author is doubtless unaware of many more. Keeping the forest in sight was always an exacting demand. By its nature this type of study is imprecise. However, studies such as this are important in gaining additional insight into complex factors influencing legislative initiatives.

## THE ROOTS OF LICENSURE IN THE UNITED STATES

Medical licensure as it exists today - within the states jurisdiction and with the determination of medical standards largely the prerogative of medical practitioners - developed historically from a combination of factors. A burgeoning view of medicine as a science based in the accumulated wisdom of the ages: "on the wisdom of ancient Greeks who emphasized objective observation of disease as a natural occurrence and developed an ethical code of professional practice, on the ancient Chinese who discovered many drugs such as ephedrine and camphor, on the Monastics of the Middle Ages whose medicine gave birth to the universities, on the great Renaissance men - Leonardo da Vinci and Vesalius - who performed pathbreaking work in the study of anatomy, on Harvey in demonstrating the circulation of blood, and Jenner and his work in vaccination (Rayak 1967, p.25)."

An early perception by practitioners and the public was that medicine was a profession. Conditions that supported this view were the following. An extensive scientific and clinical training period was required to learn a very specialized body of knowledge (Budd). The cost to the student was a lengthy training period and the money required to complete a medical education. Practitioners specialized training meant that a significant information differential existed between the practitioner and his patient. The practice of medicine required the practitioner

to integrate his scientific and clinical knowledge with individual patient circumstances, to determine the diagnosis and appropriate treatment.

The practitioner became an agent of his patient. He assumed a decision making prerogative on behalf of his patient (Touhy and Wolfson 1977).

A tiered system of medical practice had prevailed historically where the rich had the services of the skilled practitioners and the poor the services of the less skilled. However, by the middle of the nineteenth century middle class humanitarian reformers encouraged better welfare for the poor. In the practice of medicine this meant a social emphasis on one standard for medicine. All practitioners should be better trained and their skills more uniformly examined. The increased monetary cost to the poor for medical services and the reduction in the total number of practitioners largely were ignored issues (Shryock 1967).

During this time several approaches to control physician competence were tried. These methods were not coordinated between the private and public sector. In addition, standardized criteria for competency evaluation was non-existent. In some instances, medical schools issued licenses to graduates. Considering the variations in medical school educational standards, not to mention their conflict of interest in administering medical education and license issuance, with very few exceptions these licenses did not represent a uniform quality level of practitioner skill. Licenses were also issued by practicing physicians

to apprentices, by boards of health, local medical societies and occasionally by state medical boards. Again, the medical licenses awarded were only as good as the standards applied.

Early in the twentieth century a combination of events resulted in states writing statutes concerned with medical licensure. These events included:

- . An increase in the number of technical advances such as asepsis, antiseptics and vaccination. These advances gave physicians a decided advantage in the management of diseases (Carella).
- . The 1910 Flexner Report which recommended that the numbers of physicians be reduced through curtailment in the number of medical schools and imposition of stringent licensure procedures.
- . The formation of medical professional groups, such as the Federation of State Medical Boards, the National Board of Medical Examiners, specialty groups and reorganization of the American Medical Association, all concerned with standards for minimum medical competence and the protection of the practitioner's economic interests in the market place.

By the late 1920's all states designated provider boards "as their agents in regulating the provision of (medical) service (Tuohy, Wolfson, p. 59)."

These boards defined the minimum competence requirements for medical licensure, defined the range of services to be performed, determined criteria for performance evaluation and practitioner-patient etiquette.

The delegation of these powers to provider boards by the states was justified as assuring quality medical care, protecting the public. However, more than public interest were being protected. Provider interests were advanced. Provider boards could restrict the medical service marketplace - limit the number of providers and their practice modes. Indeed, by states designating providers as their agent, states set the stage for "the conflict of interest between the professional as an agent of his client and the professional as a provider of services (Tuohy and Wolfson, p. 56)."

## MEDICAL LICENSURE TODAY

Licensure is the granting of permission by "a recognized authority in order to engage in an occupation (Friedman 1929, p. 144)." Currently medical licensure is within state jurisdiction. Each state legislature enacts provisions which detail physician licensure requirements. The legislatures receive technical input from various medical groups (e.g. state appointed medical licensure boards, county medical societies and institutions of medical education and others) while reviewing changes in the state medical licensure statutes.

Even though states write their own licensure legislation, the National Board of Medical Examinators (NBME) tests (Parts I, II and III) and/or the Federation Licensing Examination (FLEX) are accepted by the states as their examinations. Approximately 75 percent of all U.S. medical graduates are licensed yearly by virtue of successful completion of the NBME. The remainder are licensed through the FLEX exam introduced in 1968 by the Federation of State Medical Boards with the National Board of Medical Examiners. The majority of FLEX applicants are graduates from foreign medical schools. Usually, foreign graduates also must pass successfully a basic science exam and an examination by the Educational Commission for Foreign Medical Graduates (ECFMG). All of these examinations have been developed by or in conjunction with

the NBME and reflect the content of medical education in the U.S. schools. In addition to these tests, most states judge a licensure candidate on the basis of personal character, medical school of graduation and in some instances citizenship.

State legislated medical licensure provisions are administered by an appointed state board of medical examiners (or in the case of California the Board of Medical Quality Assurance). Board membership is comprised largely of physicians. However, on many boards a 'public' member is appointed as well.

Licensing boards assume several functions. They are responsible for the initial licensure of physicians, the relicensure of practicing physicians (if prescribed by state statutes) and finally a quasi-judicial function. This last function is viewed in a very limited sense - the discipline of and the imposition of sanctions on the errant practitioners. The broader issue of continuing competence of licensed physicians is ignored for the most part by the boards.

#### The Implications of Physician Licensure as Presently Structured

Medical licensure statutes, as determined by the state designated practitioner boards, promote several purposes. The most obvious purpose is protection of the public's welfare through the stipulation of minimum requirements to practice medicine. Another purpose is protection of professionals' interests in the medical market place. The following details subissues within these two areas.

### Licensure as a Measure of Minimum Competence

States define the minimum levels for educational and clinical competence necessary for the practice of medicine. Because these requirements are not determined nationally there is room for variability between states in their evaluation criteria for licensure. With the acceptance by all 50 states of FLEX as a licensing exam, it is frequently argued that a universally accepted national standard for determining medical competence exists. This is not so.

" With a passing standard that is measured by the FLEX weighted average of 75 per cent...states differ in their scoring policies and minimum score requirements...It is clear these factors introduce differential leniency for candidates in obtaining full licensure through examination or endorsement. For example, the most lenient states have policies which allow the candidate to combine the best subject and day scores achieved in different trials of the examination. Some of these states allow an unsuccessful candidate to retake only those parts of FLEX which pulled his or her average below 75 per cent, thus reducing the burden of taking a three day examination all at once. The most difficult states do not allow score combinations and insist that the FLEX weighted average be obtained at a single examination trial (Butter 1976, p. 40)."

An example of two states who have relaxed their scoring policies for FLEX in response to manpower requirements are Arizona and West Virginia. Arizona allows foreign medical graduates who failed the FLEX examination by five points, to practice, for five years in underserved areas. West Virginia lowered its passing grade in the FLEX exam because a majority of applicants were failing.

Prior to FLEX licensure, endorsement policies of the states depended upon reciprocal agreements. A U.S. medical graduate or foreign medical graduate would be excused from a new licensing examination if the standards of competence set by the states were considered comparable to those of the endorsing state. FLEX was developed in part to minimize the burdens of states individualized endorsement policies, "to create a national basis for interstate endorsement and to further the uniformity of endorsement policies (Derbyshire 1969, p. 155)."

However, even with FLEX there are a number of barriers for endorsement that remain hidden. These include:

- the variations in states scoring policies for FLEX. As Dr. Butter states so aptly in her critique of FLEX, "If states will not allow combinations of day or subject scores on FLEX for licensure by examination, they usually will not accept a license for endorsement which was granted on the basis of a FLEX weighted average obtained through score combinations (Butter 1976, p. 35)."

"A number of idiosyncrasies in addition to the remnants of the reciprocity system prevent endorsement policies from being uniform throughout the country. In some states, endorsement policies provide a way of bypassing certain requirements for licensure by examination; in others, requirements are imposed upon candidates for endorsement which are not imposed upon examinees. Among the bypasses, the most significant are the policies which provide for the endorsement of credentials which do not include FLEX (Butter 1976, p. 36)."

## Licensure and the Medical Market Place

Historically, licensure has been presented by professional groups and legislators as an assurance for protecting the public's welfare. Licensure is also an effective means for decreasing competition by limiting entry and restricting the performed services to one trade. The success of organized medicine in restricting supply and competition has undoubtedly contributed to the significant rise in physicians' incomes over the years.

Since the early part of this century, physician licensure has been able to sustain high entry costs through:

- . the rigorous entrance requirements of the medical schools;
- . the cost, in time and money, to complete a medical education;
- . the licensing boards and medical societies' ability to deny a physician an economically viable practice on grounds other than academic and clinical competence (e.g. a licensing board denying a license on the basis of citizenship or personal characteristics).

As both Rottenberg and Rayak discuss, licensure tends to have a favorable income affect for the licensee. This is particularly the case in medicine where the 'information differential' between the consumer

and physician is great. The demand by the consumer for medical care is a demand for knowledge or result. It is reflected in the consumer's use of medical care services. Because of the gap in technical knowledge between the consumer and physician, consumer experience in the market place is not necessarily instructive about an appropriate diagnostic and treatment choice(s). Therefore, the physician's professional judgment is sought to determine the appropriate health care services for the consumer. The doctor knows best. In effect, the physician can determine the 'needs' of the patient and thereby positively influence his revenue generating capacity.

Organized medicine, through licensure, has placed limits on the services to be performed by other health personnel and thereby the potential revenue generating capabilities for these groups. Physicians have been very successful in limiting the services of other health professionals (e.g. nurse practitioners, physician assistants, optometrists, etc.) by restricting the procedures these occupational groups may perform as well as their prescriptive powers. When another health professional can perform a procedure at a lower cost to the patient than that charged by the physician, a savings is possible both in monetary terms and in the use of physician time. Where such a procedure is legally disallowed to the other health professional, the consumer's opportunity and monetary costs are increased.

## LICENSURE AND ITS INTERFACE WITH OTHER 'QUALITY ASSURANCE MEASURES'

Licensure is but one of several measures (frequently referred to as quality assurance measures) developed with the publically stated purpose of protection of the public's welfare. Since it is important not to view medical licensure in isolation several of these measures (certification, accreditation, continuing medical education, professional standards review organizations and others) are discussed to determine their interface with medical licensure, and how well they address the issue of quality assurance.

### Certification

Certification is "the process by which a non-governmental agency or association grants recognition to an individual who has met certain predetermined qualifications specified by that agency or association . . . . Certification may include (a) graduation from an accredited or approved program; (b) acceptable performance on a qualifying examination or series of examinations; and/or completion of a given amount of work (U.S., Dept. of HEW 1971, p. 7)." In medicine, specialty certification is bestowed by the specialty's board to the physician after the successful completion of all the above points. Certification is not legally required to practice in a specialty. However, subtle pressures are in effect

encouraging compliance. These pressures include:

- . professional pride;
- . fiscal considerations, since a certified physician is more likely to receive referrals from physician sources unknown to him;
- . granting of hospital privileges;
- . difficulty in receiving malpractice insurance.

The American Board of Medical Specialties (ABMS) is a national body comprised of specialty boards (Family Practice, Obstetrics and Gynecology, etc.) with associate members including the American Hospital Association (AHA), the Federation of State Medical Boards (FSMB), NBME and the Council on Medical Education of the American Medical Association (AMA). The ABMS approves new specialty boards, recommends policy to the specialty boards and through them participates in the accreditation of residency programs.

While this body has recommended adoption of recertification by all specialty board members, only about half of the member boards have begun recertification procedures and/or have set a time table for initiating them. Of those specialty boards with a recertification process in place, compliance to be recertified is still largely voluntary. Only four boards: colon and rectal surgery, family practice, surgery and thoracic surgery have mandatory recertification. The American Board of

Family Practice provides an example of what a comprehensive recertification process consists of: successful completion of an exam, office practice audits, and CME.

### Accreditation

Accreditation is "the process by which an agency or organization evaluates and recognizes an institution or program of study as meeting certain pre-determined criteria or standards (U.S., Department of HEW 1971, p. 7)." The Association of American Medical Colleges (AAMC) and the Council on Medical Education of the AMA formally agreed in 1942 on development of a Liaison Committee on Graduate Medical Education (LCGME) with the purpose of accrediting schools of medicine.

The LCGME composed of members from: the AMA; AAMC; ABMS; AHA; and the Council of Medical Specialty Societies; is charged with accrediting programs of graduate medical education.

While licensure, certification and accreditation have developed independently of one another, structurally they interlock.

- . The significant persons in each of these evaluative bodies are members of the medical profession. Frequently, they may serve in several capacities simultaneously e.g., state board member, on a specialty board and/or a member of an accreditation team.

- . The candidate to obtain a license and to be certified, must have graduated from an accredited medical school. Examinations for licensure and certification effectively revalidate academic retention rather than measure current clinical judgement and competency.
- . Licensure, certification and accreditation are structures that provide opportunities for professional control. Professional members determine the content of educational and clinical experience and normative standards for the practice of medicine.

### Continuing Medical Education

Continuing Medical Education (CME) is promoted today as a way for assuring physicians' continued competency. It has been popular largely because it maximizes the physicians' freedom - the choice of course subject matter, time taken, and upon completion no external evaluation of retention rate.

In 1969 the American Medical Association established voluntary physician recognition awards (PRA). These awards were to be made to physicians attaining 60 hours over a three year period in 1 of 6 study categories. Problems with voluntary attendance, meant attendance by only some physicians, and the free choice of course subject matter

would not necessarily combat a physician's deficient areas. Early criticism was made also that some courses were not comprehensive, or readily accessible to physicians in the more rural areas.

While credit is given to an in-house attempt to further physicians' knowledge, critics question the use of PRA as being too general, esoteric and unsupervised. Being able to prove the substantive value of CME to patient care performance is another problem.

During the 1970's more than half of the states began to require CME for either licensure or medical society membership. Some states, Oregon and New Mexico, implemented measures to better assure the relevance of CME subject matter (combining audits of hospital staff with Professional Standard Review Organizations review) to determine professional areas that could be addressed through CME and how to increase CME by the rural physicians.

#### Professional Standard Review Organizations

Professional Standard Review Organizations (PSRO) were enacted by Congress in 1972., "establishing a nationwide network of peer review organizations. PSROs are intended to monitor and assure the efficient utilization of health services by physicians under Medicare, Medicaid, and federally assisted maternal and child health programs. In doing so, PSROs are to accomplish two fundamental, but not always

complementary goals: 1) contain the escalating costs of Medicare and Medicaid programs by disallowing for federal reimbursement unnecessary services provided in hospitals; and 2) improve the quality of medical care by reviewing individual medical diagnoses against professionally recognized standards of medical care. In PSRO review process physicians are rated against locally determined criteria. This is intended to check subjectivity in evaluating physician performance, and sets up an external control for evaluating physician performance heretofore unevaluated (Cohen 1977, p. 22)."

According to the original statute, PSROs are comprised exclusively of physicians. These physician dominated PSROs are to some degree balanced by statewide PSRO councils, which have public membership representation. These councils (for states with three or more PSROs) are charged with performance and effectiveness review of each PSRO within its jurisdiction.

#### Other Quality Assurance Measures

Other quality assurance efforts and/or structures which directly or indirectly influence overall physician competency include:

- . hospital privileges (granting or denial of privileges);
- . hospital utilization review and tissue committees;
- . malpractice litigation (a set of controls imposed through the courts);

- . prepaid group practice organizations (through their utilization review process and financial incentives for promoting health);
- . health departments (through their epidemiological and environmental studies);
- . Federal Trade Commission's increased scrutiny of organized medicine (e.g. litigation against the AMA's code which places a ban on advertising; review of the state boards of medical examiners' structure - the composition of board membership and possible conflicts of interests).

Licensure, certification, accreditation, CME, PSROs and other measures provide a mixed array which when combined are frequently viewed as providing adequate assurance of physician competency.

The weakness inherent in this assumption is in part due to:

- . licensure's limited focus - affirmation of academic performance rather than a comprehensive measure for determining clinical competency;
- . state boards of medical examiners conflicting functions - to perform initial medical competency as well as to meet state physician supply requirements

- informally determined by medical interest groups;
- . state board members conflict of interests - being a member of the medical profession and at the same time having to evaluate fellow colleagues;
- . the voluntary nature of certification and recertification in a specialty field;
- . CME, the voluntary nature of certification for courses taken;
- . the absence of an ongoing comprehensive structure (or integrated structures) that examine clinical competency,
  1. PSROs are, by design, limited to the Medicare, Medicaid, and Maternal and Child Programs;
  2. hospital utilization and review committees are staffed by physician colleagues of those practitioners whose patient treatment and outcome are being examined. In addition, inherent in the review process are variations between regions in the evaluation criteria used for determining what is acceptable medical treatment;

. The granting or denial of hospital usage privileges is not strictly based on medical competence alone. Standards for medicine practiced in a hospital are essentially established by the medical staff. The views held by these physicians concerning the need for physicians of any specialty may ultimately influence a positive or negative fate of the applicant.

## THE HEALTH SECURITY ACT - IMPLICATIONS FOR PHYSICIANS' LICENSURE

Historically, in the United States, enacted health legislation has been incremental in nature, a product of closed door compromise with professional domination of the medical market place (delivery mode, quality assurance and pricing of services) being sustained. The proposed Health Security Act provided the opportunity for consideration of the antithesis of this pattern, most specifically in relationship to physician licensure.

This section of the thesis endeavors to explain the implications of the proposed legislation's licensure provisions. Material for this section is organized in the following manner. First, a summary of the HSA is presented. It provides a context for integration of the Act's licensure provisions into the larger whole. Second, the Act's licensure and related provisions and the changes they imply for the current system of physician licensure, are given. Third, the author's views are presented on the underlying reasons for the Act's licensure measures.

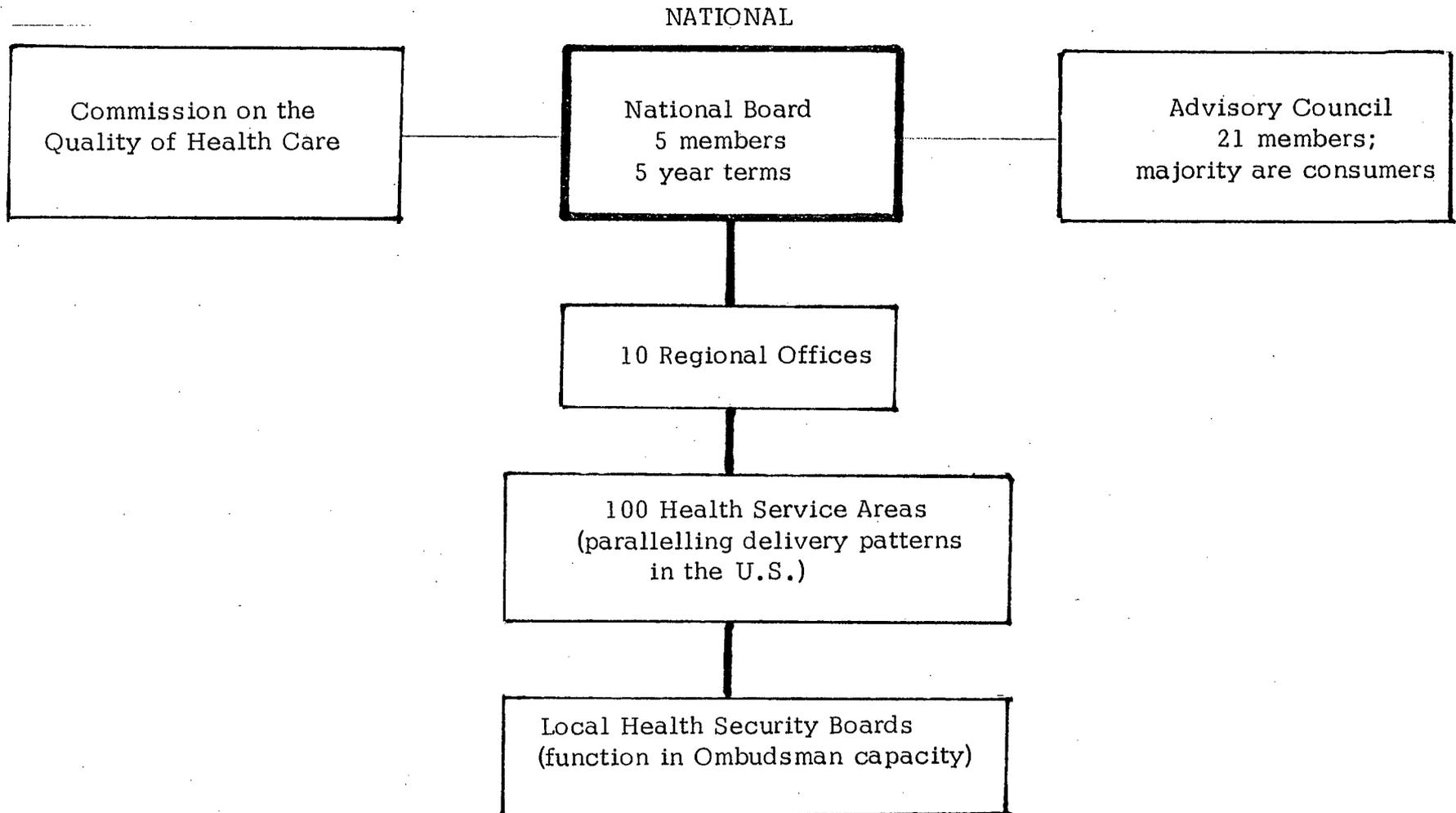
### Overview of the Health Security Act

The Health Security Act (HSA) was introduced in Congress in 1975 by Senator Kennedy and Congressman Corman. It was withdrawn from consideration four years later. The bill called for a compulsory federalized system of health care to be managed within H.E.W. by a

five-member board, with regional, area and local offices (see Figure 1). The act provided for a comprehensive range of services for U.S. citizens and resident aliens with no patient cost sharing. These services included:

- . institutional services - in-patient and out-patient hospital services; home health agency services; skilled nursing facilities up to 120 days; and psychiatric hospital benefits up to 45 days;
- . physician services including preventive care; psychiatric services of a solo practitioner were limited to 20 consultations. Ambulatory psychiatry services in the organized setting of a Group Practice Organization, etc. were not limited;
- . pathology and radiology services;
- . dental services (excluding orthodontic) for children under 15; with provisions for future extension to adults up to age 25;
- . optometrists, podiatrists, as well as psychological, physiotherapy, social work, nutrition and health education services within certain practice settings;
- . prescription drugs for chronic illnesses;
- . vision care, eyeglasses, hearing care and hearing aids.

ADMINISTRATIVE STRUCTURE FOR THE HEALTH SECURITY ACT



The financing for the program was mainly through a half-and-half combination of payroll taxes and general revenues. The payroll taxes were to be shared by the employer and employee. A distinguishing feature of the bill was its budgeting - whereby private enterprise became an instrument of public policy. As an instrument for cost control the HSA annual health care budget could not exceed expected revenues. The budget was tied to the fortunes of the economy. Should the budget be reduced due to an economic decline the legislation called for a reduction in fees and rates paid to doctors and hospitals. In effect, this clause jeopardized the time honored tradition of the private medical sector determining fees and services.

Administratively, the budgetary process was envisioned as starting annually at the local level where groups of practitioners and consumers assessed health service needs and costs, and these filtered through the regional level eventually to the national board where a national yearly budget was to be determined.

Another significant feature of the HSA was its use of reallocation of regional funds as well as patterns for the reimbursement of professional practitioners, to effect a shift in the distribution of physicians and their dominant mode of health care delivery (from solo practitioner to some form of Health Maintenance Organization). In section by section analysis by Mr. Corman of the legislation the following was stated:

In allocating funds to the regions the Board shall seek to reduce, and over the years gradually eliminate, existing differences among the regions in the average per capita amount expended upon covered health services (except when these reflect differences in the price of goods and services). To accomplish this, the Board will curtail increases in allocations to high expenditure regions and stimulate an increase in the availability and utilization of services in regions in which the per capita cost is lower than the national average. . . .

The Board will divide the allocation to each region into funds available to pay for: institutional services; physician services; dental services; furnishing of drugs; furnishing of devices, appliances and equipment; and other professional and supporting services, including sub-funds for optometrists, podiatrists, independent radiology services and other items. The percent allocated to each category of service may vary from region to region. In determining allocation to these funds they will be guided by the previous years' expenditures for each category of service but also take into account trends in the utilization of services and the desirability of stimulating improved utilization of preventive and ambulatory services (U.S., Congressional Record 1977, p. 5).

While the Act contained several options for physician reimbursement - capitation, fee-for-service, and in special instances salaries, the budgeting process and method for reimbursement favored those physicians in an HMO (capitation).

For example, in a city of 100,000 people, 25,000 may enroll in a group practice organization. Using figures cited in the example above, the Board will pay the group practice or organization \$1,625,000 ( $\$65 \times 25,000$ ) for physician services. The other 75,000 individuals elect to receive their physician services from solo, fee-for-service practitioners. The Board will create a fund of \$4,875,000 ( $\$65 \times 75,000$ ) to pay all fee-for-service bill submitted by physicians in the community, in accordance with relative value scales and unit values fixed by the Board (U.S., Congressional Record 1977, p. 6).

The intended effect of the above clause was to reduce unnecessary costs by discouraging unneeded services .

### HSA's Physician Licensure and Related Measures

As discussed earlier - the determination of standards for a license to practice medicine, the examination of and awarding of licenses to applicants , and the quasi-judicial review of errant practitioners - are all within the states' jurisdiction. The Health Security Act contained provisions to shift to the federal government the determination of physician licensure standards. The Act stated:

Professional practitioners licensed when the program begins are eligible to practice in the state where they are licensed. All newly licensed applicants for participation must meet national standards established by the Board in addition to those required by his state. While stopping short of creating a Federal licensure system for health professionals this will guarantee minimum national standards. A state-licensed practitioner who meets national standards will be qualified to provide Health Security covered services in any other state. (U.S., Congressional Record 1975, p. 25)

This section of the Act and others were reviewed with the writers of the legislation, other government officials and representatives of state licensing boards to understand the Act's intent and ramifications for the modes of health care delivery. These include:

#### The Determination of Licensure Standards

The Board with advice from the Commission on the Quality of Health Care would determine national standards for physician licensure.

Even though states could determine additional standards, once a practitioner was licensed in one state the Act implied that the practitioner could practice Health Security services in another state.

The author queried the writers of the legislation about the jurisdictional weighting of state standards as opposed to federal standards in view of the reciprocity clause. An ambiguous answer side stepping the issue was offered. The question was then posed: Why is the legislation not creating a federal licensure system? The answer given was that although federal standards would be imposed, contracts would be negotiated with the states to have them administer the examination and awarding of medical licenses to successful candidates.

#### Grandfather Clause

The Act, while indicating changes in licensure, included a grandfather clause thereby assuring that practicing physicians were automatically licensed to practice medicine in the Health Security Act program. A grandfather clause was applied to the Act's provision for mandatory specialty certification, as well.

#### Measures Aimed at Physicians Continuing Competence

No evidence was found in the act to affirm that state boards of medical examiners would continue to function as a quasi-judicial body. The Act contained various pronouncements on measures for assuring

the continuing quality of medical care. Almost invariably these measures were also linked to monitoring excess costs as well.

Major surgery and other procedures specified in regulation, are not covered services unless they are performed by a specialist (except in emergencies) and are, to the extent prescribed in regulations, performed on referral by a physician engaged in general practice. Specialists ... are those certified by the appropriate national specialty board, with a five year period allowed board eligible physicians to obtain certification, and with a 'grandfather' exception for certain physicians practicing when health security benefits go into effect (U.S., Congressional Record 1977, p. 9).

This clause would increase the magnitude of the entry cost for specialists since specialty certification implies successful completion of a minimum number of years of clinical post doctoral training and an examination. The clause also implied a more rigid definition for the permissible limits of a physician's practice (e.g. in relationship to reimbursable procedures than is currently the case.

This section of the Act also would have facilitated access to clinical reports for possible use in periodic evaluation of clinical competence (e.g. "except in acute emergencies, consultations with an appropriate specialist, as a prerequisite to specified surgical procedures; in such cases subsection (d) enables the Board to require pathology reports and clinical abstracts or discharge reports (U.S., Congressional Record 1977, p.9)."

Continuing Medical Education would be required. Noncompliance would result in disciplinary action.

PSROs legislation would be repealed; however, the door was left open, should the Board choose to use some successful PSRO organizations previously monitoring the quality of service.

HMO type organizations and hospitals would be responsible for utilization and quality of care review of member practitioners. Review committees would consist of at least two physicians and non physician members would not be required.

A central role in quality assurance was to be played by the Commission on the Quality of Health Care. This body was given the function of: developing methods for measurement of health care including patterns of care, utilization patterns, patient health initially and at the end of episodes of care, statistical norms and ranges of patient care for regions and on a national level; conduct broad health care research; and integrate findings for the development of standards and alternative methods for assessing quality assurance.

#### Related Measures Influencing The Structure of The Medical Market Place

The Health Security Act negated "corporate practice" laws in any state where they might exist. This measure was intended to facilitate interstate endorsement and creation of HMO type organizations.

As a condition for hospital participation in the Health Security System, hospitals could not discriminate "in granting staff privileges

on any grounds unrelated to professional qualifications (U.S.,  
Congressional Record 1977, p. 3)."

The Act would develop national standards for the licensure or certification of other health personnel and reciprocity for those individuals meeting national standards. The Health Security System would also greatly increase the use of these persons. The Act stated:

The restrictions which many professional practice acts impose on the use of lay assistants, and the legal uncertainties which often deter such use, discourage practices that can increase greatly, without sacrifice of safety, the volume of services which professionals can render accordingly, paragraph (3) of subsection (2) enables the Board to permit physicians and dentists, participating in public or non-profit hospitals and group practice organizations, to use ancillary health personnel, acting under professional supervision and responsibility, to assist in furnishing Health Security benefits. Such assistants may do only things which the Board has specified, and may be used only in the context of an organized medical staff or medical group. (U.S., Congressional Record 1977, p. 4-5)

#### Summary of HSA Changes to the Current Licensure Structure

In summary, the Act would modify the current structure for physician licensure in the following ways:

- . The Act would transfer jurisdictional authority for the determination of licensure standards from state governments to the federal government.
- . The federal government would contract with state governments or their designated agents to

administer the examinations of, and awarding of medical licenses to, successful candidates. State boards of medical examiners might or might not be retained by the state governments to perform this function.

- . The review of the errant practitioner would occur in a variety of settings (e.g. HMOs, hospitals and others). State boards of medical examiners would no longer perform this review function.
- . A uniform evaluation criteria for medical licensure would prevail. Even though states could specify additional licensure requirements over and above the national standards, these requirements would be meaningless because they would not be enforceable.
- . The Act would develop national standards for other health professionals (e.g. dentists) and personnel (e.g. nurse practitioners). Since the determination of standards for all health groups would be made at a national level, the influence of the health professionals and personnel at a grass roots and state level would be lessened. This would have

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- . A uniform evaluation criteria for medical licensure would prevail. Even though states could specify additional licensure requirements over and above the national standards, these requirements would be meaningless because they would not be enforceable.
- . The Act would develop national standards for other health professionals (e.g. dentists) and personnel (e.g. nurse practitioners). Since the determination of standards for all health groups would be made at a national level, the influence of the health professionals and personnel at a grass roots and state level would be lessened. This would have

implications particularly for health professionals maintaining certain vested rights, (i.e. benefits from existing economic and political privilege).

### Evaluation of the Outcome of the HSA's Medical Licensure Provisions

If the HSA was enacted, what might be the outcome of its physician licensure and related measures? The following briefly details several eventualities.

- . The determination of national standards would have an averaging effect on initial competence requirements for medicine. States with more rigorous educational and clinical standards would have their standards lowered. States with lower standards would have them raised.
- . Some initial confusion would exist in the weighting and integration of national and state medical licensure standards. States could write additional licensure standards as long as these did not inhibit, in any way, the HSA's national standards.
- . A licensed HSA physician could practice HSA services in any state. Any state's licensure standards, over and above the HSA national standards would not restrict a physician from practicing HSA

- services in the state, if the physician was licensed in another state and met HSA standards.
- . The issue of the minimum level of competence for practicing physicians would be ignored initially because of the Act's grandfather clause.
  - . The HSA physician would be relatively well protected in the field from restrictive measures applied by private professional groups. Physicians could not be denied hospital privileges on any grounds other than medical competence.
  - . Some of the structures for evaluating the continuing clinical competence of practitioners would be discontinued or modified. State boards of medical examiners would no longer review errant practitioners. PSROs would not be continued. National specifications for the appropriate delivery of medical care (e.g. who could perform services and/or how treatment be applied) would impact on the informal peer pressure and review processes. Clinical and educational training requirements (e.g. specialty certification), as prerequisites to providing certain

medical care services or in their absence substantiating laboratory and diagnostic tests, would be required to confirm appropriate patient care by a physician. These criteria would establish more rigid limits than currently exist for evaluating appropriate and inappropriate medical care in the peer review setting.

### Underlying Reasons for the Act's Licensure Provisions

A central question for this thesis is,

Why did the Act's authors include a proviso for the development of national standards for physician licensure?

Several answers to this question seem plausible in view of the Act's principal objectives. The HSA espouses numerous objectives; however, two in particular pervade most sections of the Act. These objectives are first, offering accessible medical care for all people within the confines of the U.S. and second, limiting the spiraling cost of medical care services. In view of these and other objectives, the HSA proposes restructuring the U.S. health delivery system. Its intent is to reorient the delivery of medical care from its private practice fee-for-service base to the system of care centered around group practice type organizations with reimbursement to physicians largely on a capitation basis.

To achieve this medical service pattern, physicians first must be granted permission to practice medicine and second be able to practice medicine effectively in the HSA's desired service delivery mode (HMO). One objective of the HSA - to improve the geographic maldistribution of physicians - could be hampered by state licensing bodies if states legislated restrictions on total physician supply levels. Furthermore, if local private medical interests opposed to the HSA's HMO service delivery mode were able to thwart HSA physicians from practicing medicine effectively (e.g. by denying hospital privileges and not referring patients to HSA physicians), the HSA's restructuring of the health care system could not be effected. Therefore, one answer explaining why the Act included a licensure proviso was to protect those physicians desirous of moving to a new state or already in the field performing HSA services.

A second answer to the question relates to restraints on health care costs. The HSA indirectly defines a procedure for the tiering of practitioner care to the patient ( see p. 35). The patient first visits the family practitioner for medical care. If more specialized care is indicated the patient is referred on to a specialist. Practitioner compliance with the tiered delivery approach results in reimbursement to the practitioner for the services rendered.

Theoretically, a national medical license can detail those medical care services a general/family practitioner can perform and be reimbursed for. It also can detail those services a certified specialist can perform and be reimbursed for. The logic behind this detail is that the cost for primary care services performed by a family practitioner are less than if performed by a specialist.

A third answer to the question relates to the issue of quality assurance. The Act's authors needed a rallying point for gathering public support for their bill. In recent years a number of factors focused increased public scrutiny on the issue of physician competence.

These were:

- . Increased public expenditure in health care encouraged review by the state and federal governments concerning the necessity for, and adequacy of, treatment applied, as well as the fairness of billed charges;
- . Increasing costs of medical care raised purchasers' expectations;
- . Increased payment by third party carriers resulted in an increasing scrutiny by the insurance carriers of the appropriateness and cost of patient care;

- . Increased rise in malpractice litigation and corresponding media coverage in the 1970's brought to public view, the possibility that current physician competency measures were not always effective.

In the public's mind a medical license implied an assurance that competent medical care would be practiced. The HSA authors capitalized on the public's heightened concern about quality medical care. National standards for a medical license provided a tangible rallying point for gathering public support for the bill.

## EVALUATION OF INTEREST GROUPS VIEWS ON THE HSA

The demand for legislation depends, in part, on the additional benefits that accrue to an interest group in addition to those they already possess.

A task of this study is to determine:

- . Are an interest group's underlying objectives (and the potential for loss or gain in them) an accurate predictor of the group's demand for the legislation?
- . What is the overall demand for the HSA's licensure legislation?

The formulated approach chosen to answer these questions was first to identify public and private interest groups with diverse perspectives who also were knowledgeable of medical licensure and health legislation, second, to hypothesize these groups responses to the legislation based on their underlying objectives, and third, to survey the groups to assess their views on the legislation.

### The Interest Groups

The names of organizations meeting these above criteria were compiled from various sources. These sources included HEW's Office of Policy Development and Planning, HEW's Office of Planning and Evaluation, House Subcommittee on Health and Environment, thesis advisors and literature review.

Interest groups were organized into six categories .

- . State Boards of Medical Examiners
- . Public Interest Groups
- . Provider Interest Groups
- . Health Insurance Companies
- . Medical Schools
- . Consumer Organizations

The interest groups represented in the above six categories included:

State Boards of Medical Examiners

California , Medical Quality Assurance Board  
Federation of State Medical Boards  
Florida State Board of Medical Examiners  
New Mexico Board of Medical Examiners  
Oregon State Board of Medical Examiners  
Pennsylvania State Board of Medical Examiners  
Tennessee State Board of Medical Examiners

Public Interest Groups

Council of State Governments  
Federal Trade Commission  
Group Health Plan (Minnesota HMO)  
Kaiser Permanente (HMO)

National Association of Attorneys General

SHARE (Minnesota HMO)

Veteran's Administration (federal)

Provider Interest Groups

American Academy of Family Physicians

American Academy of Orthopaedic Surgeons

American Academy of Pediatrics

American Board of Internal Medicine

American Board of Medical Specialties

American Hospital Association

American Medical Association

American Public Health Association

American Society of Clinical Pathologists

Council of Medical Specialty Societies

Educational Testing Service

Health Insurance Companies

Aetna Life & Casualty

Blue Cross-Blue Shield

Health Insurance Association of America

Illinois Mutual

Metropolitan Life

Mutual of Omaha

### Medical Schools

George Washington University

John Hopkins

Kansas University

University of California, San Francisco

University of Florida

University of Michigan

University of Minnesota

University of Washington

### Consumer Organizations

Health Research Group

Conference of Consumer Organizations

In several instances specific organizations could well have been placed into another organizational category (e.g. HMO's into provider interest groups). The decision for the organization of the sample into subgroups stemmed from the author's understanding of how such groups typically responded to health issues (Alford 1975, Feldstein 1977, Freidson 1970, Marmor and Marmor 1970). In addition consumer organizations were not grouped with public interest groups because the former represented private consumer agencies not directly involved in the delivery of health care.

### Hypothesis of Group Responses to the Legislation

"Medical care involves a variety of interest groups that tend to

view priorities from their own particular perspective and interests, and it is enormously difficult to achieve a consensus. Groups are usually reluctant to yield rights and privileges that they have already exercised, and will resist significant restructuring unless it appears that there is something in it for them (Mechanic 1972, p. 6)." In developing hypotheses on group responses to the legislation, a look at 'what is in it for them' is fundamental.

#### State Boards of Medical Examiners

There are several roles the state boards of medical examiners assume - in particular their roles as a state agency in protection of the public's welfare and, as an agent of the medical profession. With the HSA both roles are in jeopardy.

Hypothesis: state boards of medical examiners would be against passage of the HSA licensure legislation.

#### Public Interest Group

The interest groups organized into this group come from more diverse reference points than the other groups. Very generally, the Act's effects on these groups would be:

The HMO's, the desired health care delivery mode of the HSA, would be able to maintain their organizations largely intact.

- . The Veteran's Administration medical services would be unaffected by the legislation. The health care program in place for military personnel and their dependents would be retained and function independently of the HSA.
- . The Federal Trade Commission's role would presumably be expanded in policing anti-competitive activities. The commission most likely would have better access to local and regional data through the national board.
- . The Council of State Governments and the National Association of Attorneys General would have a diminution in their jurisdictional authority. However, this loss could be balanced by increased federal dollars coming into their state and absorbing costs previously borne by the states.

Hypothesis: This subgroup would be favorably disposed towards the legislation.

#### Provider Interest Group

The main objectives of provider interest groups are to maintain professional autonomy and control, maximize the professionals' income potential and, determine acceptable quality of care levels. The HSA

threatens all three of these objectives. It divests providers of their controlling influence over the medical market place.

Hypothesis: The provider interest groups would be universally against passage of the HSA.

#### Health Insurance Group

Central objectives of the health insurance group are to maximize the output of its organization and to reduce costs for unnecessary services. In the HSA private health insurance companies do not exist.

Hypothesis: The health insurance group would be against passage of the HSA bill. However, the group might be favorably inclined towards measures in the Act designed to scrutinize unnecessary medical services.

#### Medical School Group

Objectives for medical schools include maintaining their autonomy, maximizing their prestige and expansion in class size and research facilities. Setting standards for excellence in medical training are prerequisites for the maximization of the above objectives.

The medical school group could benefit from the HSA's licensure legislation by participating in the technical determination of standards for licensure, standards for medical care services as a whole, and in providing CME. These benefits to the group could be offset by a

potential loss in autonomy. A national health insurance program could attach strings to federal monies for medical education in order to achieve national manpower objectives.

Hypothesis: The medical schools would not support the HSA bill.

### Consumer Group

The objectives of consumer groups vary. Generally, however, they are consistent with improving quality and access to medical care. They may differ in their views concerning whether the public or private route is the best vehicle for achieving improved quality and access.

Hypothesis: The consumer groups would be in favor of the HSA.

### The Survey

The mailed survey, a multiple choice questionnaire with opportunity for written comments (see Appendix I) was conducted in early 1979. Survey questions queried, in general, the organizations' views on present physician licensure method and process, on continuing versus periodic licensure, on licensure as a mechanism for limiting the numbers of physicians and the variety of practice modes, and finally reactions to the HSA's proposed changes in physician licensure.

The survey's sample consisted of forty-one organizations. A small sample for the survey was chosen for several reasons. The small sample was more appropriate for the in-depth questioning contained in the survey. Economically it was not feasible to collect and analyze large sample data.

One follow-up letter was sent to non-respondents three weeks after the survey mailing. In addition non-respondents were telephoned to urge their completion of the survey. The two reasons given for not responding were:

Our organization has not developed a policy position on the HSA and/or physician licensure. Therefore, a response by us would be in appropriate at this time.

We have a policy of not answering surveys.

Twenty-three, fifty-six per cent of the sample, returned completed surveys. Table I showed the sample's response rate by organizational grouping.

TABLE I

## PHYSICIAN LICENSURE SURVEY

## SAMPLE SIZE AND RESPONSE RATE BY ORGANIZATIONAL GROUPING

<u>Organizational Groupings</u>	<u>Total Cell Size</u>	<u>Number of Respondents</u>
Boards of Medical Examiners	7	4
Public Interest Groups	7	6
Provider Interest Groups	11	7
Health Insurance Groups	6	3
Medical Schools	8	3
Consumer Organizations	<u>2</u>	<u>0</u>
TOTALS	41	23

The interest groups who returned completed surveys were as follows:

State Boards of Medical Examiners' Group

Federation of State Medical Boards

New Mexico, State Board of Medical Examiners

Florida State Board of Medical Examiners

Pennsylvania State Board of Medical Examiners

Public Interest Group

Council of State Governments

Federal Trade Commission

Group Health Plan

Kaiser Permanente

SHARE

Veteran's Administration

Provider Interest Group

American Academy of Orthopaedic Surgeons

American Academy of Pediatrics

American Board of Internal Medicine

American Board of Medical Specialties

American Medical Association

American Public Health Association

Council of Medical Specialty Societies

Health Insurance Group

Blue Cross-Blue Shield

Aetna Life and Casualty

Mutual of Omaha

Medical Schools Group

Kansas University

University of Florida

University of Michigan

Consumer Organization Group

No respondents

The sample's non-respondents were a particular concern because they increased sampling error. This especially was the case for consumer groups with a zero response rate and to a lesser extent for the medical schools and health insurance groups. No interpretation of consumer group (privately based public oriented groups) was possible. Interpretation of the medical school and health insurance groups was possible but was viewed as largely speculative. The survey response rate for the boards of medical examiners, public interest and provider interest groups was better (greater than 50% response). With less margin for sampling error, the survey results for these groups was more reliable.

#### Data Compilation and Analysis

Question responses were tallied, percentages run, and written respondent comments noted for the full sample and the six health organizational subgroups. Data tables were drafted detailing group percent responses for all questions. The sample interest groups were instructed to check one or more items in answering the questions. Therefore, the tables' percentages were based on the number of replies, rather than on the number of organizations. The tables were arranged so that the vertical parameter, the possible answers to a question, reflected the full sample's ordered ranking of response -- from most

frequently chosen to least frequently chosen. This rank ordering of answers provided a basis for comparison of the similarities and differences between the various health group categories and the full sample. The tables' horizontal parameters, the organizational groups, were ordered as follows: the full sample; state medical examiners; public interest; provider interest; health insurance companies; and medical schools.

The survey response rate by health insurance and medical school groups was low. While the author is aware that the low response rate for these groups limited the interpretative reliability of the survey, the question responses by these groups are contained on the tables that follow, for the reader's reference. The reader should note that consumer group data is not shown in the tables. This group failed to return completed questionnaires; making analysis of their views impossible.

TABLE II

Question 1: WHAT DOES YOUR ORGANIZATION SEE AS THE DESIRED GOALS OF PHYSICIAN LICENSURE

	<u>FULL<sup>1</sup> SAMPLE</u>	<u>STATE MEDICAL EXAMINERS</u>	<u>PUBLIC INTEREST GROUP</u>	<u>PROVIDER INTEREST GROUP</u>	<u>HEALTH INSURANCE COMPANIES</u>	<u>MEDICAL SCHOOLS</u>
<u>ANSWERS</u>						
Initial competency test	30%	20%	37%	50%	33%	22%
Method whereby medical profession sets minimum competency standards	30%	40%	25%	--	33%	33%
Tool for determining continuing competency	22%	20%	37%	33%	33%	22%
Other	8%	20%	--	--	--	--
Opportunity for each state to determine competency levels meeting their physician supply requirements	5%	--	--	17%	--	11%
Control mechanism over the numbers of individuals entering the profession	2%	--	--	--	--	11%
A means for influencing control over the type of practice setting	-- <sup>2</sup>	--	--	--	--	--

TABLE III

Question 2: WHICH OF THE FOLLOWING DOES YOUR ORGANIZATION SEE AS BEING ACCOMPLISHED BY CURRENT PHYSICIAN LICENSURE

	<u>FULL SAMPLE</u>	<u>STATE MEDICAL EXAMINERS</u>	<u>PUBLIC INTEREST GROUP</u>	<u>PROVIDER INTEREST GROUP</u>	<u>HEALTH INSURANCE COMPANIES</u>	<u>MEDICAL SCHOOLS</u>
<u>ANSWERS</u>						
Initial competency test	25%	20%	25%	17%	25%	40%
Method whereby medical profession sets minimum competency standards	25%	33%	18%	--	50%	40%
Opportunity for each state to determine competency levels meeting their physician supply requirements	12%	11%	6%	50%	--	--
Control mechanism over the numbers of individuals entering the profession	10%	11%	18%	--	--	--
Tool for determining continuing competency	10%	11%	6%	--	25%	20%
A means for influencing control over the type of practice setting	7%	11%	18%	--	--	--
Other	7%	--	6%	33%	--	--

<sup>1</sup>Column totalled down.

<sup>2</sup>-Indicates no response.

## QUESTIONS 1 & 2

Questions 1 and 2 of the survey queried the organizations' views on the desired goals and perceived effects of physician licensure.

### For the Full Sample:

- . Sixty per cent of the respondents viewed licensure's goals as either (1) an initial competency test and/or (2) an internal method for establishing minimum competency standards. Fifty per cent of the respondents felt these goals were in fact being effected.
- . Nearly one-fourth (22%) of the respondents felt a goal of licensure was to determine continuing competency. Only one-tenth of the respondents felt this was being accomplished.
- . Three of the questions' answers revealed a reverse trend in responses between perceived goals and actual realities. While these percentage differences were small, they did reflect a variation in attitude from ideal and reality. Survey respondents did not view the following points as appropriate goals for licensure. Licensure should not be a mechanism by which (1) states determined their physician supply (5%), (2) restricted entry into the medical profession (2%) or, (3) restricted the types of physician practice settings.

When queried about the effects of licensure, respondents answered with (1) 12% (a gain of 7%), (2) 10% (a gain of 8%), and (3) 7% (a gain of 7%) respectively.

### Organizational Groups

For the most part the organization groups showed response patterns similar to the Full Sample. However, some differences are worth noting.

- . The provider group responded that the goals of licensure were first an initial competency test (50%) and second a tool for determining continuing competency (33%). Responding to licensure's effects, 50% of the group indicated that licensure was instead a way for states to determine the competency standards that met its supply requirements. In Table I, only 17% of provider respondents felt this was a goal for licensure.
- . The public interest group responded that the goal of licensure should not be as a control mechanism for supply and practice styles (0%). However, when queried about licensure's effects, 36% felt licensure was a means of control over supply (number of physicians entering the profession, and over the type of practice styles).

### Author's Comment

It is interesting that all groups except for the provider group had a low per cent response (in Tables I & II) for licensure as either an initial competence test or as a method for the profession to set minimum competence standards.

Licensure is a set of criteria (examination and other) for determining minimum qualifications to enter into a trade. The low response rate by most groups on the above issue implies medical licensure is perceived as either not accomplishing this objective or this objective is only one of several objectives.

Determining continued competence for these same groups is as important a goal as the above. There is less consensus on whether licensure accomplishes this goal.

### Written Comments\*

Public Interest Group --

"Limiting the ability of allied health personnel (e.g. nurses, opticians) to perform lesser functions of physicians through scope of practice restrictions."

Provider Interest Group --

"Licensure per se is not a test of competency but provides evidence that a person has met education

---

\*Respondents were not identified in the written comments section. Confidentiality of individual response was promised to elicit a greater survey response.

requirements and passed a test of knowledge to entitle the licensee to practice his or her profession legally under state statutes."

"A political control over one of several licensed professions by States -- absolutely no assurance of level of competence of a licensed holder."

TABLE IV

QUESTION 3

Question 3: IN WHAT AREAS OF THE LICENSURE PROCESS DO YOU FEEL THE FEDERAL GOVERNMENT HAS A LEGITIMATE ROLE TO PLAY

	<u>FULL SAMPLE</u>	<u>STATE MEDICAL EXAMINERS</u>	<u>PUBLIC INTEREST GROUP</u>	<u>PROVIDER INTEREST GROUP</u>	<u>HEALTH INSURANCE COMPANIES</u>	<u>MEDICAL SCHOOLS</u>
None of the stated	60%	100%	28%	80%	50%	67%
Policy development	20%	--	42%	--	50%	--
Standard development	10%	--	14%	--	--	33%
Other	5%	--	14%	--	--	--
No response	5%	--	--	20%	--	--
Administering testing	--	--	--	--	--	--

The majority of most groups indicated that the federal government had no role to play in physician licensure. There were exceptions, however. A 50% and 42% response by the health insurance and public interest groups respectively signaled a federal role in licensure policy development. Thirty-three per cent of the medical schools and 14% of public interest groups indicated approval for the federal government's involvement in developing standards for physician licensure.

### Author's Comments

It is interesting that medical schools gave the highest per cent response (33%) to a federal role in the determination of licensure standards. While this percentage is a minority view of the medical school group, it may reflect an understanding that medical schools are an excellent reference source for the federal government in determining standards. It is also interesting that the medical schools visualize no role for policy development at the federal level. At the same time, medical schools believe in global concept of competence as a technological concept - not variable across states.

The state board of medical examiners and provider group exclude the federal government from any role in the licensure process. These groups have a great deal to lose should the federal government assume jurisdictional authority for medical licensure.

## QUESTION 4

Question 4: WHAT IS YOUR RESPONSE TO CREATION OF FEDERALLY DEVELOPED STANDARDS FOR PHYSICIAN LICENSURE, TO BE ADMINISTERED BY STATE LICENSING BOARDS

	<u>FULL SAMPLE</u>	<u>STATE MEDICAL EXAMINERS</u>	<u>PUBLIC INTEREST GROUP</u>	<u>PROVIDER INTEREST GROUP</u>	<u>HEALTH INSURANCE COMPANIES</u>	<u>MEDICAL SCHOOLS</u>
<u>ANSWERS</u>						
Oppose	56%	100%	60%	30%	100%	33%
Favor	16%	--	20%	--	--	66%
No Response	11%	--	--	--	--	--
Indifferent	5%	--	20%	20%	--	--

Strong views are reflected in the respondents answers to this question.

Most groups, in a clear majority, were opposed to Federal intrusion in standards development for licensure, even if the state licensing boards maintained administrative responsibility for the standard's implementation. Medical schools, again, assumed a minority view, 66% in favor of federally developed standards. Again this response may reflect an ideological view as well as a promotion of their own self-interests.

Author's Comment

Of particular interest in this question is the low percentage response (20%) by the public interest group favoring federally developed

standards for physician licensure. The presence of several HMO's in this group may account for the response. HMO's have physicians on staff and in administration positions.

### Written Comments

#### State Licensing Boards --

"Licensing is a policing power of the States and is covered under the tenth amendment to the U.S. Constitution."

#### Public Interest Group --

"The present system works well in Minnesota, additional bureaucracy and regulation is not cost effective."

"The issue is not who develops or enforces standards but rather what the goals of licensing are."

#### Provider Interest Group --

"Local and state needs for medical services and organizations for medical practices vary to such a degree that federal standards of any significance would be virtually impossible to develop without inhibiting the development of medical services in many of the localities."

"Would not take the local needs into account."

"Local determination of standards is more realistic and cheaper, despite physician mobility. Other national standards such as certification (no cost to government) cover the latter."

Health Insurance Group --

"See no need for federal intrusion. Where it has intruded, the paperwork has multiplied without appreciable improvement."

TABLE VI

QUESTION 5

Question 5: DO YOU FEEL THE PREVALENT USAGE OF NATIONAL BOARD EXAMINATIONS (NBE) AND FEDERATION LICENSING EXAMINATIONS (FLEX) AMONG STATES AS LICENSING EXAMINATIONS REPRESENTS A NATIONAL STANDARD BEING APPLIED ACROSS STATES?

	<u>FULL SAMPLE</u>	<u>STATE MEDICAL EXAMINERS</u>	<u>PUBLIC INTEREST GROUP</u>	<u>PROVIDER INTEREST GROUP</u>	<u>HEALTH INSURANCE COMPANIES</u>	<u>MEDICAL SCHOOLS</u>
<u>ANSWERS</u>						
Yes	83%	67%	100%	80%	100%	100%
No	11%	33%	--	20%	--	--
No response	5%	--	--	--	--	--

The majority of all sampled groups feel that FLEX and NBE are representative of a national standard in licensure. A minority view, 33% of State Medical Examiners and 20% of the Provider Interest Group, feel this is not the case.

Author's Comment

While most groups are comfortable with FLEX and the NBE, a minority of the state boards of examiners group are not. They know how licensure standards are variable from state to state (e.g. in the score weighting of FLEX). In fact, within their national organization a serious and long standing movement is afoot to strengthen and expand upon the existing FLEX exam.

It is not surprising that the majority views of the groups view FLEX and NBE as representative of a national standard. Not until 1980 has a document detailing the fifty states' standard measures for licensure, been compiled and distributed.

### Written Comments

#### Public Interest Groups --

"This is a national standard, albeit not the most sensitive test of clinical competence. Knowledge testing is one thing, an educational program engagement is another and certification is another. Viewed in isolation each can be considered deficient in one aspect. It is the total effect that is important, not just licensure or reregistration of a license with requisites."

#### Provider Interest Group --

"These two exams, which are well standardized and validated, give a common series of questions on information for all physicians seeking licensure. They are not tests of performance nor are they intended to be."

"LCME accreditation of medical schools is another national standard, particularly since student admissions

are so competitive. With PL 94-484 even more U.S. physicians will be graduates of U.S. medical schools."

"These (tests) are not political in origin. The political arms of many states elects to use these identified evaluation mechanisms as one criteria required in licensing acts. Criteria vary sharply between states."

Health Insurance Group --

"The NBE represents standardized testing given on the same day throughout the U.S. Similarly, FLEX provides the same standardization and opens a pathway to the foreign graduate to prove competence. Both tests are prepared by a similar body of individuals -- mostly outside educators of no political orientation."

TABLE VII

QUESTION 6

Question 6: THERE IS VARIATION AMONG STATES REGARDING THEIR POLICIES FOR THE SCORING OF FLEX.  
 WHAT IS YOUR ASSESSMENT OF THIS FLEX SCORING VARIATION?

	<u>FULL SAMPLE</u>	<u>STATE MEDICAL EXAMINERS</u>	<u>PUBLIC INTEREST GROUP</u>	<u>PROVIDER INTEREST GROUP</u>	<u>HEALTH INSURANCE COMPANIES</u>	<u>MEDICAL SCHOOLS</u>
<u>ANSWERS</u>						
Lessens the value of FLEX for facilitating interstate licensure endorsement and reciprocity	28%	57%	27%	-	50%	29%
Provides each State with the opportunity for determining its own physical competency levels	17%	--	18%	20%	--	29%
Scoring variations do not account for significant difference in overall physician competency between states	17%	--	27%	20%	--	14%
No response	14%	--	18%	40%	--	--
Other	10%	--	9%	20%	50%	--
Allows states flexibility to meet own physician supply requirements	7%	33%	--	--	--	14%
Results in significant differences between states concerning their physician competency	3%	--	--	--	--	14%

The low per cent response for answers by the full sample and most groups limits interpretation of the question answers. However, there are several interesting response patterns worth noting. A majority of state medical examiners view the variability in states' FLEX scoring policies as lessening the exam's value in licensure endorsement and reciprocity. This group also with a 33% response views the scoring variability as a way for states meeting their medical manpower needs. This same group

gives a zero response to "scoring variations do not account for significant differences in overall physician competency between states", "provides each state with the opportunity for determining its own competency levels", and "results in significant difference between states concerning their physician competency."

The response pattern for other groups were as follows. Fifty per cent of the health insurance group and 29% of the medical school group answered that variations in FLEX scoring between states limited FLEX's value in licensure endorsement and reciprocity. A 29% response by the medical school group supported the view that FLEX scoring was an appropriate method for states to specify their standards for medical licensure. Public interests, provider interest and the health insurance groups gave no response and therefore no support for the view that variability in FLEX scoring was a way for states to influence their physician supply.

#### Author's Comment

The state medical examiners and medical school groups show a consistent thinking pattern; that licensure (and its representative test) are mechanisms for control of medical manpower. Groups whose response patterns are not consistent, are the public interest and provider interest groups. With 18% and 20% response respectively,

they indicate the FLEX scoring variation allows states to determine their own physician competence levels. At the same time they give a zero response to it allowing states flexibility in meeting their own physician supply requirements.

TABLE VIII

QUESTION 7

Question 7: WOULD YOUR ORGANIZATION BE SUPPORTIVE OF FLEX BEING ADMINISTERED BY STATE MEDICAL BOARDS WITH ONLY ONE SCORING POLICY BEING APPLIED?

<u>ANSWER</u>	<u>FULL SAMPLE</u>	<u>STATE MEDICAL EXAMINERS</u>	<u>PUBLIC INTEREST GROUP</u>	<u>PROVIDER INTEREST GROUP</u>	<u>HEALTH INSURANCE COMPANIES</u>	<u>MEDICAL SCHOOLS</u>
Yes	52%	67%	80%	--	50%	67%
Undecided	23%	37%	--	25%	50%	37%
No response	17%	--	20%	50%	--	--
No	5%	--	--	25%	--	--

Except for the provider interest group, all groups respond favorably (at least 50% or greater) to the adoption of one FLEX scoring policy for the nation as a whole. There is, however, a minority response by these same groups indicating some indecision on this issue. For the provider interest group there is a zero response for 'yes', a 25% response rate indicating 'no' and a sizeable undecided and no response (25% - 50% respectively).

Author's Comment

While there is support for FLEX with one scoring policy applied to all states' licensure candidates, within the present licensure structure,

there is still substantial indecision on the issue. The provider interest group is obviously the most recalcitrant.

TABLE IX

QUESTION 8

Question 8: WOULD YOU SUPPORT THE ABOVE SUCH MOVE IF THE SCORING POLICY WAS DETERMINED BY THE:

	<u>FULL SAMPLE</u>	<u>STATE MEDICAL EXAMINERS</u>	<u>PUBLIC INTEREST GROUP</u>	<u>PROVIDER INTEREST GROUP</u>	<u>HEALTH INSURANCE COMPANIES</u>	<u>MEDICAL SCHOOLS</u>
<u>ANSWER</u>						
Federation of State Medical Boards (FSMB)	20%	50%	22%	--	50%	--
Special committee comprised of significant members of representative professional bodies (eg. FSMB, NBME, AMA, medical education institutions, etc.)	20%	--	22%	--	--	100%
No response	20%	--	11%	60%	--	--
Other	12%	25%	--	20%	50%	--
Oppose such moves to standardize scoring policy across the states	12%	25%	11%	20%	--	--
Special committee comprised of state representatives appointed by each state legislature	8%	--	22%	--	--	--
Federal government	4%	--	11%	--	--	--

Answers to this question are not generalizable across groups.

Fifty per cent (50%) of the state medical examiners and the health insurance groups, respectively, indicate support for the Federation of State Medical Boards determining one national scoring policy for FLEX.

One-hundred per cent (100%) of medical schools respondents support adoption of a national scoring policy for FLEX if this policy is determined by a special committee comprised of significant members of representative professional bodies (e.g. Federation of State Medical Boards, National Board of Medical Examiners, AMA, medical education institutions.)

Sixty per cent (60%) of the provider interest group ignored this question entirely by not responding.

Of interest, a minority (11%) of the public interest group respondents, felt the federal government had a role in determining a scoring policy.

### Author's Comments

What seems to be at work in the group responses to the question is the following logic -- egocentricity is DNA bound. An explanation of this logic and its application to organizations is as follows. A human being responds to situations in ways that preserve and promote his self-interests. This response pattern is generalizable across the human race from infancy onward. A parallel pattern for organizational behavior applies. A response pattern by an organization can be anticipated, in part, depending upon whether an outside action that impacts on it preserves, promotes or diminishes the organization's self-interests. If the outside action preserves or promotes the organization, it usually supports the action. If the action diminishes its structure or functioning, the organization opposes the action. The following group response patterns support this logic. Half of the state medical examiners support such a move if the FLEX scoring policy is determined by them. A minority view (25%) like things just

as they are. One-hundred per cent (100%) of medical schools support the idea when they are included in a special committee. The public interest group's support for such action is divided, reflecting the mixed composition of this group's respondents -- medical practitioners in HMO's, a group representing the interests of state governments and several federal agencies. The provider group has much to lose and little to gain. The group's response pattern reflects this circumstance. Health insurance companies want either to assure this function is retained by the FSMB or by some 'other' group (possibly with health insurance company representatives included).

#### Written Comments

##### Private Interest Group --

"There is no single scoring policy. Each state should use the exam within the legal authorities established by state legislatures to help meet the specific needs of persons residing within each state."

TABLE X

QUESTION 9

Question 9: DO YOU FEEL PHYSICIAN LICENSURE SHOULD BE RENEWED PERIODICALLY TO ASSURE THE PHYSICIANS CONTINUED COMPETENCY?

	<u>FULL SAMPLE</u>	<u>STATE MEDICAL EXAMINERS</u>	<u>PUBLIC INTEREST GROUP</u>	<u>PROVIDER INTEREST GROUP</u>	<u>HEALTH INSURANCE COMPANIES</u>	<u>MEDICAL SCHOOLS</u>
<u>ANSWER</u>						
Yes	72%	100%	100%	20%	50%	100%
No	16%	--	--	60%	--	--
Maybe	11%	--	--	20%	50%	--

The majority of all groups, excepting the provider interest group, respond with either a categorical yes or maybe to periodic renewal of physician licensure as a method to assure continued competency.

Sixty per cent (60%) of Provider Interest respondents oppose periodic licensure renewal.

Author's Comment

The provider group response reflects its self-interest. A majority (60%) want to maintain the freedom to practice unencumbered by periodic licensure renewal. The view frequently espoused to support this view is that physicians monitor one another through the in-place private mechanisms to review medical care outcome. A minority view (20% for, 20% maybe) supports the premise that some periodic 'public' review

is of value. Certainly the other interest groups support this view, the state medical examiners, public interest and medical schools with the greatest per cent response. The big question is how.

### Written Comments

Provider Group --

"Licensure and competency are not equivalent."

"Licensure is not the means for determining the performance of physicians. Many other devices are already in place including: PSRO's; appointments to hospital staffs; membership in professional societies; patient responsibilities; actions of grievance committees of medical societies; and as a last resort the courts are, all involved together with patients in the evaluation of performance of physicians."

"Only when validated methods of assuring physician competency in performance and skills are available. It is simplistic to believe otherwise. Only the grossest evaluation of acceptable competency has been applied at initial licensure, to date."

Health Insurance Group --

"Inflicting the present process more than once would do little for society and only provide physicians with more reason to self-righteously defend their prerogative. If something that really measured competency were cited, it would be worthwhile to have periodic relicensure to assure competency."

"Some form of continuing education is necessary to assure knowledge of new and recent developments. Unfortunately the differences in practice -- e.g. teaching schools versus county practice -- do not permit a testing procedure uniformly adequate."

Medical School Group --

"Continuing education is a questionable way of assessing continuing competence."

## TABLE XI

## QUESTION 10

Question 10: WHAT TYPES OF PERIODIC REQUIREMENTS WOULD BE ACCEPTABLE TO YOU?

	<u>FULL SAMPLE</u>	<u>STATE MEDICAL EXAMINERS</u>	<u>PUBLIC INTEREST GROUP</u>	<u>PROVIDER INTEREST GROUP</u>	<u>HEALTH INSURANCE COMPANIES</u>	<u>MEDICAL SCHOOLS</u>
<u>ANSWER</u>						
Continuing education	45%	75%	30%	67%	25%	42%
Periodic file assessment of diagnosis, treatment and outcome measures	16%	25%	30%	--	25%	29%
Re-examination	12%	--	20%	--	--	--
PSRO review	12%	--	20%	--	25%	29%
Other	12%	--	--	37%	25%	--

While the answer choices in this question, in part, mix apples with oranges (by including competency evaluation methods—periodic file assessment, PSRO review, etc. - along with CME), the fruit basket reflects the array of methods commonly considered and implemented to 'assure' physician competency.

Continuing education was the most frequently chosen 'acceptable' method for assuring continued competency. This is not surprising since CME is extensively offered; was initiated by the medical profession; gives the physician great latitude in the choice of educational topic; and does not involve an external evaluation of the physician's performance.

### Author's Comment

CME, not surprising, receives its greatest support from state medical examiners (75%), the provider interest (67%), and medical school (42%) groups. These groups have a good deal to gain by CME being the predominate periodic tool for relicensure. The state medical examiners, who are understaffed and lack adequate fiscal resources, find CME a nonthreatening plausible vehicle to assure that physicians are exposed to new information. Providers have maximum freedom of choice with CME, and, of course, medical schools offer programs in CME.

On balance the medical schools, public interest and health insurance groups' responses indicate the desire for other review processes as well. Only the public interest group espouses a re-examination.

### Written Comments

#### Public Group --

"Reliance on one indicator would not accomplish the desired results of assuring the public of continuing "clinical" competence."

#### Provider Interest Group --

"Continuous assessment through peer review, staff meetings, opportunities for participation in

continuing medical education of all types , and reporting of untold incidents in which the reporting mechanism assures both confidentiality and due process for both the patient and the physician."

Continuing Education -- "As a partial requirement"

Periodic File Assessment -- "Too expensive; records illegible."

PSRO Review -- "Does not assure quality of care."

General Comment -- "Probably will turn out to be a combination of strategies for assessment."

TABLE XII

QUESTION 11

Question 11: AT WHAT LEVEL WOULD YOU WANT THE CONTENT OF PERIODIC REQUIREMENTS TO BE DETERMINED?

	<u>FULL SAMPLE</u>	<u>STATE MEDICAL EXAMINERS</u>	<u>PUBLIC INTEREST GROUP</u>	<u>PROVIDER INTEREST GROUP</u>	<u>HEALTH INSURANCE COMPANIES</u>	<u>MEDICAL SCHOOLS</u>
<u>ANSWER</u>						
State	63%	100%	50%	60%	50%	50%
Other	36%	—	50%	40%	50%	50%
Federal	--	--	--	--	--	--

The majority of the Full Sample (63%) and at least 50% of all the groups, indicate approval for states to determine the content in physician continuing competency requirements. To a lesser extent (36% of the full sample and 50% or less of each group) support was indicated for 'other' institutions to assume this function. All groups agree that there is no role for the federal government to play in this area.

Author's Comment

Except for the state medical examiners - who would like increased control - all other groups seem to want a blend of state and private participation in determining periodic requirements for continued competence. This view reflects the status quo. What is interesting is that the public interest groups sees no role for the federal government in this area. This non response is in contrast to their minority response in Question 4 that favors federally developed standards for physician licensure.

Written Comments

Public Group --

Periodic requirements to be determined:

"Nationally, not necessarily federal."

"States to determine content within federal guidelines."

"The hospital and other information sources must coordinate their assessment of competence policies.

Self-assessment using validated tools is most conducive to learning and continuing competence."

Provider Interest Group --

"Professional societies working in conjunction with boards of trustees and representatives of the public together with the staffs of individual hospitals and other institutions giving health care."

The Health Insurance and Medical School Groups --

Had comments like the following:

"By medicine and educators of physicians without political intervention at any level."

TABLE XIII

QUESTION 12

Question 12: AT WHAT LEVEL WOULD YOU WANT PERIODIC REQUIREMENTS TO BE ADMINISTERED?

<u>ANSWER</u>	<u>FULL SAMPLE</u>	<u>STATE MEDICAL EXAMINERS</u>	<u>PUBLIC INTEREST GROUP</u>	<u>PROVIDER INTEREST GROUP</u>	<u>HEALTH INSURANCE COMPANIES</u>	<u>MEDICAL SCHOOLS</u>
State	70%	100%	60%	75%	50%	67%
County	11%	--	40%	--	--	--
Other	11%	--	--	25%	--	33%
Federal	5%	--	--	--	50%	--

At least fifty per cent (50%) or more of all groups (state medical examiners (100%) followed by the provider interest (75%), medical schools (67%), public interest (60%) and health insurance (50%) groups) want periodic requirements to be administered by the state. Only the health insurance group support an administrative role at the federal level. This is inconsistent with their previous response patterns.

Author's Comment

While some inconsistency in response from previous question responses is evident, an overall response pattern prevails. Organizations at the state or private level are the appropriate structures for licensure and continuing competence policy development, standard determination and administration.

TABLE XIV

QUESTION 13

Question 13: SOME CRITICS OF LICENSURE AGREE THAT LICENSURE IS USED AS A MEANS FOR A STATE TO REGULATE ITS SUPPLY OF PRACTITIONERS. DO YOU FEEL THERE SHOULD BE FLEXIBILITY IN LICENSURE STANDARDS ACROSS STATES TO ENABLE EACH STATE TO INCREASE OR DECREASE ITS SUPPLY OF MEDICAL DOCTORS, ACCORDING TO ITS OWN POPULATION NEEDS?

	<u>FULL SAMPLE</u>	<u>STATE MEDICAL EXAMINERS</u>	<u>PUBLIC INTEREST GROUP</u>	<u>PROVIDER INTEREST GROUP</u>	<u>HEALTH INSURANCE COMPANIES</u>	<u>MEDICAL SCHOOLS</u>
<u>ANSWER</u>						
No	73%	67%	66%	60%	100%	100%
No response	15%	--	16%	40%	--	--
Yes	10%	37%	16%	--	--	--

The majority of all groups felt that physician licensure should not be a method whereby states can affect (+ or -) their supply of physicians. A minority of the State Medical Examiners (37%) and public interest groups (16%) disagreed.

Author's Comment

To answer in the affirmative to this question is to contradict the publicly espoused goals of most of these organizations. The majority response, "no", by all groups reflects this reality.

Written Comments

Public Group --

"The mixing of standards and quantitative determinations would result in even greater variations in standards."

QUESTION 14

Question 14: AT PRESENT PHYSICIAN LICENSURE IS STATE LEGISLATED AND ADMINISTERED. THE POINT IS SOMETIMES MADE THAT THE STATE LICENSING BOARD IS TOO DEPENDENT ON ORGANIZED MEDICAL GROUPS FOR DETERMINING THE CONTENT OF LICENSURE LEGISLATION AND STATE BOARD MEMBERSHIP. DO YOU AGREE?

<u>ANSWER</u>	<u>FULL SAMPLE</u>	<u>STATE MEDICAL EXAMINERS</u>	<u>PUBLIC INTEREST GROUP</u>	<u>PROVIDER INTEREST GROUP</u>	<u>HEALTH INSURANCE COMPANIES</u>	<u>MEDICAL SCHOOLS</u>
No	62%	33%	50%	100%	50%	67%
Yes	37%	67%	50%	--	50%	33%

A majority of the full sample, provider interest, and medical school groups, agreed that state licensing boards are not too dependent on medical groups for determining board membership or licensure legislation content. Public interest and health insurance groups are divided on the issue. The state medical examiner group indicates organized medical groups are significant players in determining licensure legislation and state board membership.

Author's Comment

The licensure literature (Cohen, McCleery et.al., Butter 1977) frequently refers to the fact that state boards are limited in carrying

out their functions because of external pressures from private medical interests. The state boards' majority response confirms this view. The minority board response (33%) represents one of two alternatives - a conservative board(s) whose values and approach align perfectly with the private medical interests, and/or board(s) where enough administrative monies and protective statutes exist to protect the boards from outside pressure. The former situation seems more likely.

#### Written Comments

##### State Medical Examiners --

"In many states the members of the boards (licensing) are appointed from lists of physicians submitted by governors by the medical associations."

"If the board members believe that amendments to private practice acts must obtain approval from the medical society which usually has more influence than the Board."

##### Public Group --

"Medical societies, often with the advice of the AMA, do attempt to influence legislation but in most instances, the effort is oriented towards improving quality of care

or monitoring performance. Where legislative bodies act alone, errors and concessions to splinter pressure groups have led to bad legislation."

Provider Group --

"Licensure standards are quite low and do not restrict entry in the profession. The profession seems a logical resource to lay legislatures. Not all groups exercise cynical self-interests."

"Licensure of physicians is a public act and as such is determined by state legislatures. In the development of legislation and in the administering of licensing laws, the public as well as the profession should clearly be participants in the process."

TABLE XVI & XVII

QUESTION 15 and 16

Question 15: IS YOUR GROUP FAMILIAR WITH THE PROPOSED NATIONAL HEALTH INSURANCE LEGISLATION GENERALLY CALLED THE HEALTH SECURITY ACT OR SOMETIMES REFERRED TO AS THE KENNEDY-CORMAN BILL?

	<u>FULL SAMPLE</u>	<u>STATE MEDICAL EXAMINERS</u>	<u>PUBLIC INTEREST GROUP</u>	<u>PROVIDER INTEREST GROUP</u>	<u>HEALTH INSURANCE COMPANIES</u>	<u>MEDICAL SCHOOLS</u>
<u>ANSWER</u>						
Yes	82%	100%	75%	80%	50%	100%
No	11%	--	25%	--	50%	--
No response	5%	--	--	20%	--	--

Question 16: IS YOUR GROUP FAMILIAR WITH THE HEALTH SECURITY ACTS PROPOSED LEGISLATION CONCERNING PHYSICIAN LICENSURE?

No	55%	67%	80%	20%	50%	67%
Yes	38%	33%	20%	60%	50%	33%
No Response	5%	--	--	20%	--	--

While the majority of groups were familiar with the HSA, only the provider interest and health insurance groups, had half or more respondents familiar with its provisions concerning physician licensure.

TABLE XVIII

## QUESTION 17

Question 17: ...WITH THE WIDESPREAD USE OF FLEX AND NATIONAL BOARD EXAMINATIONS TODAY, DO YOU FEEL THIS CLAUSE (LICENSURE ENDORSEMENT CONTAINED IN HSA) OF THE ACT AMOUNTS TO A SIGNIFICANT CHANGE FOR PRACTICING PHYSICIANS?

<u>ANSWER</u>	<u>FULL SAMPLE</u>	<u>STATE MEDICAL EXAMINERS</u>	<u>PUBLIC INTEREST GROUP</u>	<u>PROVIDER INTEREST GROUP</u>	<u>HEALTH INSURANCE COMPANIES</u>	<u>MEDICAL SCHOOLS</u>
Yes	61%	67%	50%	60%	50%	100%
No Response	16%	--	25%	--	50%	--
No	11%	33%	--	20%	--	--
No significant importance	11%	--	25%	20%	--	--

At least 50% or more of all groups view the HSA interstate licensure endorsement policy as a significant change from the current acceptance and usage (by states) of FLEX and the National Boards Exams. A minority view (state medical examiners (33%), provider interest (20%) groups) feel this amounts to no change. Twenty-five per cent of public interest and 20% of provider interest see no significant importance in this measure.

### Author's Comment

Medical schools (100%), state medical examiners (67%) and provider interest (60%) groups view the HSA licensure endorsement policy as a significant change from the current norm. As such, these groups probably see the potential for intrusion on existing jurisdictional prerogatives that protect their self-interests.

### Written Comments

#### Public Group --

"Physicians in the V.A. will not be primarily affected. Physicians in the private sector will probably not view it as a major loosening of any restriction except in California."

"It removes from the states the power to limit the number of licensees through licensing standards."

#### Provider Group --

"Licensure is still determined today by local standards according to needs perceived by state officials familiar with local resources, problems, needs, etc."

"Yes, in essence the HSA would supersede the constitutional rights of states to determine requirements for licensure in each of the states. The degree

to which such a change would affect actual practice is extremely difficult to predict."

For responders answering: no significant importance

"Mobility is now very great"

"Physician mobility is not determined by licensure."

TABLE XVIV

QUESTION 18

Question 18: DO YOU FEEL THE ENDORSEMENT CLAUSE REFERRED TO IN QUESTION 17 WILL ENCOURAGE PHYSICIANS TO MAKE A PHYSICAL MOVE TO ANOTHER REGION?

	<u>FULL SAMPLE</u>	<u>STATE MEDICAL EXAMINERS</u>	<u>PUBLIC INTEREST GROUP</u>	<u>PROVIDER INTEREST GROUP</u>	<u>HEALTH INSURANCE COMPANIES</u>	<u>MEDICAL SCHOOLS</u>
<u>ANSWER</u>						
No	52%	33%	50%	75%	100%	33%
Yes	23%	67%	--	--	--	67%
No response	23%	--	50%	25%	--	--

State medical examiners and the medical school groups feel that the HSA interstate licensure endorsement will encourage physicians to move to another region. All other groups anticipate no such effect.

Author's Comment

The author is unsure of what these responses, in isolation, may mean other than the obvious -- some groups see the potential for movement by physicians with a national endorsement clause and others do not.

## Written Comments

### State Medical Boards --

"Yes, it would encourage and stimulate hopping from one state to another and hinder effective physician discipline."

### Public Group --

"The significance is negligible right now since FLEX and reciprocity does not pose a significant barrier at present."

"Probably not except for states such as Florida and other "semi-sunshine" belt states (which overall may not be a positive effect.)"

### Provider Interest Group --

"May be one factor in decision to move but not the main one."

### Health Insurance Group --

"No, significant problems are necessary before a competent physician chooses to abandon an established practice. It would appear that there would be a natural gravitation toward financially secure or retirement locations."

TABLE XX

QUESTION 19

Question 19: DO YOU FEEL THAT THE HEALTH SECURITY ACT'S ENDORSEMENT CLAUSE LINKED TO THE ACT'S FINANCIAL INCENTIVES MIGHT BE SUFFICIENT TO EFFECT OVERALL PHYSICIAN DISTRIBUTION?

<u>ANSWER</u>	<u>FULL SAMPLE</u>	<u>STATE MEDICAL EXAMINERS</u>	<u>PUBLIC INTEREST GROUP</u>	<u>PROVIDER INTEREST GROUP</u>	<u>HEALTH INSURANCE COMPANIES</u>	<u>MEDICAL SCHOOLS</u>
No	55%	50%	40%	30%	50%	33%
Yes	33%	50%	40%	20%	--	67%
No response	11%	--	20%	--	50%	--

In general, the response pattern in Question 18 held in Question 19. The addition of economic incentives linked to interstate licensure endorsement was not viewed as sufficient incentive to affect a significant change in the national distribution of physicians. Some minor response shifts between the two questions are worth noting.

Author's Comments

The state medical examiner group in Question 19 was evenly divided (50% - yes; 50% no). One might surmise from the group's greater 'yes' response to Question 18, that they feel interstate endorsement is more significant than economic incentive in impacting on physician mobility.

The public interest group responses were different in Questions 18 and 19. In Question 18 the response pattern was 50% 'no', 0% 'yes'. In Question 19 the response pattern was 40% 'no', 40% 'yes'. While the fiscal incentives linked with licensure reciprocity increased the 'yes' response in Question 19, this response was still not a majority view response.

The provider interest group responses to the two questions were almost identical.

The health insurance group in Question 18 answered an unequivocal 'no' but, showed some ambivalence in response to Question 19. In Question 19, 50% responded 'no' and 50% checked no response. This variance may indicate responder uncertainty regarding the effects of linking licensure endorsement to economic incentives.

The medical school group response pattern was identical in both questions - the interstate endorsement clause and economic incentives will encourage physicians to move (67%).

### Written Comments

#### Public Group --

"Such incentives can result in a temporary shift of physicians into "underserved areas". However, there are always a complex of reasons why such areas are underserved - financial return being only one."

Provider Interest Group --

"Financial disincentives are not the principal reasons for the assumed geographic maldistribution of specialists. Is there a geographic maldistribution of Safeway Stores."

Health Insurance Group --

"The evidence regarding the effects of distribution of various financial incentives is mixed."

"No, similar methods have not been effective in the past."

TABLE XXI

QUESTION 20

Question 20 WHAT OTHER INCENTIVES, IF ANY, DO YOU FEEL WOULD EFFECT A PHYSICIANS  
REDISTRIBUTION TO UNDERSERVED AREAS?

<u>ANSWER</u>	<u>FULL SAMPLE</u>	<u>STATE MEDICAL EXAMINERS</u>	<u>PUBLIC INTEREST GROUP</u>	<u>PROVIDER INTEREST GROUP</u>	<u>HEALTH INSURANCE COMPANIES</u>	<u>MEDICAL SCHOOLS</u>
Easy access to advanced medical facilities	44%	50%	44%	38%	33%	60%
Continuing education opportunities	29%	33%	22%	25%	33%	40%
Other	17%	17%	22%	12%	33%	--
No response	8%	--	11%	25%	--	--

While the overall percentage responses by group vary, the scaling of answers is the same. Easy access to advanced medical facilities is considered the most important other incentive influencing physician redistribution. Continuing education opportunities is ranked second. The percentage reply for the 'other' category by the physician group is low. This is surprising in view of family considerations, cultural amenities, etc., valued highly in choice of practice location.

Author's Comments

Overall, the response by providers in Questions 18-20 indicates

that a much more complex series of conditions must exist to effect a redistribution of physicians. The health insurance group is ambivalent and/or negative about a redistribution being effected under the HSA program. The public interest group is uncertain, as well. Only state medical examiners and medical schools consistently see a redistribution effected.

#### Written Comments

State Medical Examiners --

"Provisions for coverage in his absence."

Public Groups --

"Incentives provided by local communities."

"Presence of medical students and housestaff; opportunities for academic recognition; and decentralized educational campuses (AHEC's)."

"Physicians, in general, need to flock together to practice good medicine, and, in general, require as most highly trained persons certain cultural amenities. These two basic wants are not present in "underserved areas."

Provider Interest Group --

"Other numerous studies have been undertaken on selection of practice sites of MD's. There are

literally dozens of variables as there are in the decisions of most professional people. No single factor seems to be dominant."

"Personal safety for physicians and staff; better education for family members; intellectual stimulation in the community, cultural advantages, etc."

TABLE XXII

QUESTION 21

Question 21: WHICH OF THE ABOVE (QUESTION 20), IF ANY, DO YOU FEEL IS MOST IMPORTANT TO REDRESS PHYSICIAN MALDISTRIBUTION?

	FULL SAMPLE	STATE MEDICAL EXAMINERS	PUBLIC INTEREST GROUP	PROVIDER INTEREST GROUP	HEALTH INSURANCE COMPANIES	MEDICAL SCHOOLS
ANSWER						
Easy access to advanced medical facilities	42%	25%	25%	33%	33%	67%
Other	35%	25%	50%	33%	33%	33%
Continuing education opportunities	21%	50%	25%	33%	33%	--

Several unanticipated response patterns are worth noting. In Question 21 the medical school group does not rate CME as important in redistribution. This is inconsistent with their response to Question 20. The state medical examiner group response pattern is almost reverse to that in Question 20.

Author's Comments

Written comments by respondents provide the most telling answers to this question. The overall tone of comments in both Questions 20 and 21

indicated that for the most part no one factor is viewed as affecting a change in the distribution of physicians.

Written Comments

Public Group --

"My point is that short of coercion it can't be done."

Provider Interest Group --

"Only supply and demand has some potential. No worthwhile physician will expose himself to a practice site without essential equipment and auxiliary personnel."

Health Insurance Group --

"All are a must and a minimum."

Medical School Group --

"More authentic financial and professional incentives."

TABLE XXIII

## QUESTION 22

Question 22: ...WITHIN THE HEALTH SECURITY ACT, THERE IS A CLAUSE WHICH NEGATES ANY RESTRICTIONS ON FORMATION OF GROUP PRACTICE ORGANIZATIONS. WHAT DO YOU SEE AS BEING THE EFFECT OF THESE CLAUSES?

	<u>FULL SAMPLE</u>	<u>STATE MEDICAL EXAMINERS</u>	<u>PUBLIC INTEREST GROUP</u>	<u>PROVIDER INTEREST GROUP</u>	<u>HEALTH INSURANCE COMPANIES</u>	<u>MEDICAL SCHOOLS</u>
<u>ANSWER</u>						
Opening greater diversity in practice modes.	36%	60%	44%	--	--	40%
Creating more competition among practicing physicians for patients	16%	20%	22%	--	--	20%
Decreasing the political influence of local and state medical societies.	16%	20%	22%	--	--	20%
Other	12%	--	--	33%	--	--
No response	12%	--	--	67%	--	--
Severing traditional ties between professional medical organizations and state legislative bodies.	8%	--	11%	--	--	20%

The state medical examiner (60%), public interest (44%) and medical school groups (40%) indicate that this clause in the Act will open greater diversity in choosing practice modes. To a lesser extent (approximately a 20% response by each group) these groups view that more competition among practitioners and a decrease in the political influence of local and state medical societies, will result. A small percent response by the medical school (20%) and public interest (11%) groups indicates the potential for the severing of traditional ties between professional medical organizations and state legislative bodies. The provider interest and health insurance groups give inconclusive responses or do not respond at all.

### Author's Comment

The question needs to be asked, why have the provider groups made inconclusive responses? Why have the health insurance groups not answered at all? In the case of the latter group, with so few respondents, it is difficult to judge. Concerning the former group, this clause in the Act touches sacrosanct ground - the ability of private medical groups indirectly to thwart attempts at forming HMO or other untraditional practice modes.

Provider interest groups have learned the value of not confronting these threats directly. Instead, through quiet efforts, organized medical groups place the HMO or untraditional practitioners on the defensive, forcing them to expend time and money to justify the new practice approach. The inconclusive response by the provider group is in keeping with this approach. Maintain a low profile and identify with 'quality medicine'; make the newcomer a radical.

### Written Comments

Public Group --

"Like all legislation which has been recently introduced to deal with the availability of medical services, it is virtually impossible to anticipate what the effects of such legislation would be if enacted, particularly

since the regulations which derive from the legislative authority cannot be predicted in advance. The choices in this question by no means cover all the possibilities and cannot be answered categorically."

TABLE XXIV

QUESTION 23

Question 23: HOW DO YOU VIEW THE HEALTH SECURITY ACT'S PHYSICIAN LICENSURE PROVISION --  
SHIFT FROM STATE TO FEDERALLY DESIGNATED STANDARDS TO BE ADMINISTERED BY THE STATE

ANSWER	FULL SAMPLE	STATE MEDICAL EXAMINERS	PUBLIC INTEREST GROUP	PROVIDER INTEREST GROUP	HEALTH INSURANCE COMPANIES	MEDICAL SCHOOLS
Encroachment by the Federal gov't into the area of standards of physicians competency.	28%	38%	25%	33%	33%	25%
Other	15%	12%	8%	50%	33%	--
An increase in gov't control over physicians and subsequently a lessening of control by professional organizations.	15%	12%	16%	16%	--	25%
A potential loss in autonomy for individual physicians.	10%	12%	--	--	33%	25%
An equalizer which will upgrade some state requirements and downgrade other state requirements.	7%	--	16%	--	--	12%
A potential increase in autonomy for indiv. physicians (eg. greater choice in practice mode, greater assurance of income, etc.)	7%	12%	16%	--	--	--
One tool which when linked w/others (economic incentives) provides greater diversity in the choice of practice modes for physicians.	5%	12%	8%	--	--	--
An increase in gov't control over physicians with professional bodies becoming more political in motivation & becoming more of an information resource body for government.	5%	--	8%	--	--	12%
Out of order!	2%	--	--	--	--	--

Author's Comments

The data for Question 23 do not allow for any clear cut interpretations. However, by combining the responses of the first three rank ordered answers, two generalizations are possible. The HSA licensure provisions are viewed as an encroachment by the federal government into the domain of state and private medical interests. An increase in federal influence is viewed as diminishing the role of other

health professional bodies. Only two groups (public interests 16%, medical school groups 12%) respond to the issue of the overall effect on medical standards. The predominate issue is a loss of professional control.

### Written Comments

#### State Medical Examiners --

"A potential for the following: directing where a physician practices, his specialty choice and income; a means for making the practice of medicine a public utility and; relegating physicians to the role of technicians."

#### Provider Interest Group --

"A wasteful, premature approach to a far more complicated situation than the Cohen Committee (HEW) and others have appreciated."

"None of these questions addresses the limitations that may be placed on patients in their ability to choose organizational patterns of treatment, which should be the fundamental question, together with the availability of medical services, addressed in this questionnaire."

## Summary of the Data

Very generally, the dominant attitudes conveyed by Survey respondents were as follows.

- 1) Licensure is the measurement of a candidate's minimum level of educational and clinical skills, with minimum standards determined by medical professionals. Respondents agree medical licensure accomplishes this goal. In practice, licensure accomplishes some other objectives as well. It provides states with a useful tool for influencing their physician supply levels. A majority view of respondents hold that this effect is inappropriate. A minority view holds that licensure provides a way of influencing the pattern of medical practice modes.
- 2) FLEX and NBE are viewed as representing a national standard, applied across states. However, the states' variations in acceptable scores for FLEX lessons the exam's value as a tool for interstate endorsement. A majority of respondents were in favor of one scoring policy for all states particularly if existing provider-oriented organizations (FSMB, NBME, etc.) determined the scoring policy.

- 3) The federal government has no role to play in physician licensure or evaluation of continuing competence. A minority view held that a federal role may be appropriate in licensure policy development. (Exactly the role that the federal government currently participates in).
- 4) Licensure should be renewed periodically.
- 5) Periodic requirements, particularly CME, are acceptable ways for assuring continued competence.
- 6) Members of the state boards of medical examiners indicate that these boards are dependent on medical groups for determining board membership and licensure legislative content.
- 7) The licensure endorsement clause contained in the HSA is considered a significant change from the status quo. If enacted, the clause would supersede the constitutional rights of states to determine their own licensure requirements.
- 8) The majority view is that the HSA's licensure endorsement clause alone, or when linked to economic incentives, will not be sufficient incentive to encourage physicians to move

to other regions in the U.S. The state medical examiners and medical school respondents disagree.

- 9) The redistribution of physicians across regions is considered a complex issue, - a multitude of factors influence a physician's employment location (easy access to medical facilities, CME, economic incentives.
- 10) The HSA licensure provisions are viewed as an encroachment by the federal government into the domain of state and private medical interests.

#### Summary of the Interests Groups' Positions

##### State Board of Medical Examiners

State boards of medical examiners support national standards for initial licensure if determined by the FSMB. They are in favor of CME as a way of influencing a practitioner's continued competence. They are very much in favor of relicensure or some way of verifying practitioners' ongoing competence. They also are in a weak position to implement strong measures in this direction because of the significant influence of professional organizations in their functions.

This group is cognizant of the potential for manipulating manpower levels through medical licensure. Overall they favor national standards but not if the federal government determines them. Therefore, this interest group opposes the HSA legislation.

### Public Interest Group

The public interest group feels the present licensure system imposes restrictions on developing a truly competitive medical market. They favor national standards only if developed and administered at the state level with input from local or state, public and private agencies, and from national private organizations.

The public interest group did not appear well informed on the differences between states in their licensure standards. They were better informed about problems in the market place due to restrictive professional practices. Overall, this group opposed the HSA legislative initiatives.

### Provider Interest Group

The provider interest group views the present licensure structure as working just fine. These groups control the medical market place where services are performed. They exercise their influence by determining minimum quality of care standards, establishing initial competence measures for new applicants and relicensure, and sanctioning errant practitioners. It should be remembered that these controls are exercised informally. With this influence, it is not surprising that the provider interest group opposes the HSA legislation.

## Health Insurance Group

Health insurance group respondents show a good deal of inconsistency of response. In view of this and the small number of respondents for the group, no general statements are possible from the survey alone.

## Medical School Group

As mentioned at the beginning of this section, the number of respondents for the medical school group is small. Therefore, general statements made here should be viewed with caution.

Many of the medical school group's views concur with those of the state medical examiners, e.g. the positive value of national standards, licensure renewal and CME. The medical school group does not envision a role for the federal government either in the determination of a national scoring policy or in the administration of licensure. A minority view by the group indicates a role for the federal government in developing licensure standards. In this instance, medical schools are appropriate expert consultants for the federal government in the development of standards. Concerning the issue of relicensure, the group indicates that determination of the content for periodic requirements is the prerogative of the states and private medical interests, not the federal government.

The medical school group opposes the use of licensure as a restrictive market devise.

Overall, this group opposes the HSA legislation.

#### Comments

The author's hypothesized positions for these interest groups were correct for all groups except the public interest group. No testing of the author's hypothesized position for the health insurance group was possible for the reasons enumerated earlier.

## CONCLUDING COMMENTS

Medical licensure is a vehicle for sustaining or acquiring control of the medical market place. It can affect the supply and distribution of medical manpower as well as influence reimbursement for services rendered.

The HSA proposed divesting states and the medical profession of this control. The Act's licensure provision was part of a larger whole intended to restructure the U.S. health delivery system. In effect, the Act brought the federal government into direct competition with states and private interests for control over the medical market place.

The authors made several fatal mistakes. First, they did not adequately evaluate how passage of the HSA would result in a significant loss of autonomy and influence for the states and private medical interests. Consequently the authors underestimated the degree of support for the status quo and hostility to the federal government. Second, they overestimated the public's discontent with the quality of medical care being provided and consequently the public's support for a change in the status quo.

Regarding the first point, it is hardly surprising that the Health Security Act with support from only the AFL-CIO, and the Committee for National Health Insurance was withdrawn from consideration in 1979.

As Dr. Feldstein wrote in Health Associations and the Demand for

Legislation, demand for legislation "represents the additional (or marginal) benefits to a group from additional legislation. The benefits of health legislation for a health professional association will depend upon what benefits the legislation provides in addition to the legislative benefits the members of the group already possess. . . . The demand for legislation is also an indication of how much a group is willing to pay for those legislative benefits."

The HSA's licensure provision would have resulted in the federal government assuming control over:

- . The determination of minimum standards for physician licensure;
- . the requirements for relicensure;
- . the standards for medical licensure reciprocity.

In addition, the HSA would have provided the federal government with the authority to review practitioners' patient records and to expand upon the scope of services performed by associated and allied health professionals. In effect, these measures and others in the Act would have:

- . removed the jurisdictional powers of states to determine minimum and continuing competency standards;
- . reduced the influence of private professional organizations in determining those services that could be performed only by a physician;

- provided greater legal redress for HSA physicians against measures (e.g. denial of hospital staff privileges) designed to limit the ability of physicians to practice medicine in the field;
- assumed the tasks of the private health insurance companies, and threatened medical schools with indirect measures for influencing the production of certain medical specialties (e.g. family practitioners).

The Health Security Act conflicted with the fundamental goals of professional groups (autonomy, practice styles, income determination, quality review). Non-profit organizations such as voluntary hospitals, Blue Cross, and educational institutions were also threatened by a loss of autonomy. The findings of the physician survey confirmed these views. The state medical boards, public interest, provider interest, and medical school groups opposed the legislation.

An unintended effect of the legislation was to unite these interest group organizations to work against the passage of the legislation. Together they exerted strong influence since they were well organized and funded. A stalemate was effected. The proposed legislation was withdrawn.

A second mistake made by the authors of the legislation was to overestimate the public's support for enactment of national health insurance legislation. After the surge in public attention on the issue of quality medical care, with the malpractice crisis of 1975, other national issues (e.g. energy, inflation) diverted the public's attention away from the issue of quality medical care and national health insurance.

The demand for legislation by the public depends upon their degree of dissatisfaction with the status quo. The lack of any significant public support for the HSA indicates a complacent attitude on the issue of national health insurance.

What then could have been done differently in the HSA? State boards of medical examiners feel significant influence is exerted by professional bodies over their functions. If the Act had contained a provision to provide technical assistance and/or monetary subsidy, it would have benefited boards in a number of ways. State boards of medical examiners have significant resource limitations that hinder their ability to perform all legally designated functions. These additional resources would allow boards to hire more staff. Subsidy would allow them to develop more sophisticated data systems. These systems would provide states with ready access to physicians' records and provide a capability for correlation analysis between

physicians' examination performance and patient care measures.

Lastly, supplementary assistance would support research in new methods of determining continuing clinical competency and encourage the implementation of pilot projects.

Perhaps the politically wisest approach would have been to ignore the issue entirely. The HSA would have had less impact on the geographic and specialty maldistribution of physicians. It would have been able to promote a restructuring of practice modes (from private practice to HMOs) through its physician reimbursement plan and jurisdictional authority. Initially, in some states there would have been efforts to disrupt the program (e.g. denial of licensure endorsement). However, this initial disruption would have been overcome if the HSA had strengthened and supported the roles of state boards of medical examiners. Eventually, it would have coopted state boards and in the long run achieved significant control over medical licensure.

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APPENDIX

Dear Sir:

I'm a graduate student in health planning presently working on my thesis topic - Physician Licensure. Part of my thesis task is to survey diverse views on this topic so that the subject matter is fully explored.

The purpose of the enclosed survey is to determine how groups such as yours view current physician licensure, and what their reactions are to proposed changes in physician licensure as contained in the Health Security Act (proposed by Senator E. Kennedy and Congressman Corman).

Your completion of the enclosed survey will contribute greatly towards accomplishment of my thesis requirements.

Thank you for your cooperation.

Sincerely,

Sandra Defoe-Dunn

SURVEY OF PHYSICIAN LICENSURE

DATE:

NAME OF ORGANIZATION:

NAME AND POSITION OF SURVEY RESPONDER:

NAME:

POSITION:

## INSTRUCTIONS

This survey is designed for you, the responder, to check (✓) one or more items for each question which answers your groups position on the topic of physician licensure. In some instances additional information is sought from you which requires a written response. Space has been left for these responses.

Your cooperation in completing this survey is greatly appreciated.

## STATE VS. NATIONAL LICENSURE

1. What does your organization see as the desired goals of Physician Licensure? (✓ applicable items)

- 1. Initial competency test.
- 2. A method by which the medical profession sets minimum competency standards.
- 3. An opportunity for individual states to determine the competency levels they see as meeting their physicians supply requirements.
- 4. A means of control over the numbers of individuals entering the profession.
- 5. A tool for determining continuing competency.
- 6. A means for influencing control over the type of practice setting.
- 7. Other, please specify.

2. Which of the following do you see actually being accomplished by current Physician Licensure.

- 1. Initial competency test.
- 2. A method by which medical profession sets minimal competency standard.
- 3. An opportunity for individual states to determine the competency levels they see as meeting their physician supply requirements.
- 4. A means of control over the number of individuals entering the profession.
- 5. A tool for determining continuing competency.
- 6. A means for influencing control over the type of practice setting.
- 7. Other, please specify.

3. In what areas of the licensure process do you feel the Federal government has a legitimate role to play.

- 1. Policy development.
- 2. Standards development.
- 3. Administering testing.
- 4. None of the above.
- 5. Other, please specify.

4. What is your response to creation of Federally developed standards for physician licensure, to be administered by State licensing boards?

- 1. Favor
- 2. Oppose      Why:
- 3. Indifferent

5. Do you feel the prevalent usage of NBE (National Board Examinations) and FLEX (Federation Licensing Examination) among states as licensing examinations represent a national standard being applied across states?

- 1. Yes
- 2. No      Why:

6. There is variation among States regarding their policies for the scoring of FLEX. What is your assessment of this FLEX scoring variation?

- 1. It provides each State with flexibility so as to meet it's own physician supply requirements.
- 2. It provides each State with the opportunity for determining it's own physician competency level.
- 3. The scoring variations do not account for a significant difference in overall physician competency between States.
- 4. It results in significant differences between States concerning their physician competency.
- 5. It lessens the value of FLEX in terms of its potential for facilitating interstate Physician Licensure endorsement and reciprocity.
- 6. Other, please specify.

7. Would your organization be supportive of FLEX being administered by State Medical Boards with only one scoring policy being applied?

- 1. Yes
- 2. No
- 3. Undecided

Why:

8. Would you support the above such move if the scoring policy was determined by the:
- 1. Federation of State Medical Boards. (FSMB)
  - 2. A special committee comprised of state representatives appointed by each state legislature.
  - 3. Federal government.
  - 4. A special committee comprised of significant members of representative professional bodies (eg. FSMB, NBME AMA, medical educational institutions, etc.)
  - 5. Other, please specify.
6. Would you oppose any such move to standardized scoring policy across States?

#### CONTINUING VS. PERIODIC LICENSURE

9. Do you feel Physician Licensure should be renewed periodically to assure the physician's continued competency?
- 1. Yes
  - 2. No      If no, why:

10. What type of periodic requirements would be acceptable to you?

- 1. Continuing education.
- 2. Re-examination.
- 3. Periodic file assessment of diagnosis, treatment, and outcome measures.
- 4. PSRO review.
- 5. Other, please specify:

11. At what level would you want the content of periodic requirement to be determined?

- 1. State
- 2. Federal
- 3. Other, please specify.

12. At what level would you want periodic requirements to be administered?

- 1. County
- 2. State
- 3. Federal
- 4. Other

LICENSURE AS A CONTROL OVER VOLUME

13. Some critics of licensure argue that licensure is used as a means for a State to regulate its supply of practitioners. Do you feel there should be flexibility in licensure standards across States to enable each State to increase or decrease its supply of medical doctors, according to its own population needs?

1. Yes  
 2. No  
 3. Discuss

14. At present Physician Licensure is State legislated and administered. The point is sometimes made that the State Licensing Board is too dependent on organized medical groups for determining the content of licensure legislation and State Board membership.

Do you agree?       Yes     No  
Explain why:

15. Is your group familiar with the proposed National Health Insurance legislation generally called the Health Security Act or sometimes referred to as the Kennedy-Corman Bill?

1. Yes  
 2. No

16. Is your group familiar with the Health Security Acts proposed legislation concerning Physician Licensure?

- 1. Yes
- 2. No

17. Under the Health Security Act, a State licensed physician meeting the Health Security Licensure standards, may practice within the Health Security System in any other State, "The scope of his permissible practice being governed by the law of the State in which he is practicing."

In effect this licensure endorsement clause means a physician's mobility would no longer be subject to individual State licensure practices. With the widespread use of FLEX and National Board Examinations today, do you feel this clause of the Act amounts to a significant change for practicing physicians?

- 1. Yes
- 2. No
- 3. No significant importance

Why:

18. Do you feel the endorsement clause referred to in Question 17 will encourage physicians to make a physical move to another region?

- Yes
- No

Why:

19. Within the Health Security Act there are financial incentives to encourage physicians to practice in underserved areas. Do you feel that the Health Security Act's endorsement clause linked with these financial incentives might be sufficient to effect overall physician distribution.

Yes

No

Why:

20. What other incentives, if any, do you feel would effect a physician's redistribution to underserved areas.

1. Continuing education opportunities.

2. Easy access to advanced medical facilities.

3. Other, please specify.

21. Which of the above, (Question 20), if any, do you feel is the most important to redress physician maldistribution.

1.

2.

3.

22. Licensure has been used in the past as one tool for screening physician applicants who may choose a differing practice mode from the norm. Within the Health Security Act, there is a clause which negates any restrictions on formation of group practice organizations. What do you see as being the effect of these clauses?
- 1. Opening up greater diversity in practice modes.
  - 2. Creating more competition among practicing physicians for patients.
  - 3. Decreasing the political influence of local and State medical societies.
  - 4. Severing traditional ties between professional medical organizations and State legislative bodies.
  - 5. Other, please specify.
23. How do you view the Health Security Act's Physician Licensure Provision - shift from State to Federally designated standards to be administered by the State.
- 1. An excellent move which will raise overall initial physician competency.
  - 2. An equalizer which will upgrade some State requirements and downgrade other State requirements.
  - 3. An encroachment by the Federal government into the area of standards of physician competency.
  - 4. One tool which when linked with others (eg. economic incentives) provides greater diversity in the choice of practice modes for physicians.
  - 5. An increase in governmental control over physicians and subsequently a lessening of control by professional organization.
  - 6. An increase in governmental control over physicians with professional bodies becoming more political in motivation and becoming more of an information resource body for government.
  - 7. A potential loss in autonomy for individual physicians.
  - 8. A potential increase in autonomy for individual physicians (eg. greater choice in practice mode, greater assurance of income, etc.)
  - 9. Other please specify.

March 30, 1979

Dear Sir,

On February 28th, 1979 I sent you a survey on Physician Licensure. I would be most indebted to you if you or a member of your staff would take a brief moment to answer the survey which is to form the basis of my Masters thesis - "The relevance of physician licensure in the proposed Health Security Act" .

As a graduate of higher learning yourself, you can no doubt understand not only the importance input of this nature has on a thesis, but also as an instrument of recording a balanced reading from a professional group.

I trust I may rely upon you for the valuable information I seek.

Thank you.

Yours sincerely,

Sandra Defoe Dunn