

Not the Last Word: Why Can't I Set Fractures in Vermont?

Joseph Bernstein MD

On a recent family trip to Vermont, we needed to rent a car. At the airport, I offered my driver's license and credit card at the rental counter. My wife, we were told, would be allowed to drive the vehicle without showing either. I was handed the keys and we were off.

Somewhere southeast of Burlington, VT, USA on Route 89, a curiosity came to mind. Vermont is willing to

recognize my Pennsylvania driver's license, a card given for passing a road test more than 35 years ago. Vermont is also willing to recognize my Pennsylvania marriage license, and that piece of paper was issued without any testing at all. On the other hand, Vermont refuses to honor my hard-won Pennsylvania medical license. If I tried to treat fractures at the base of Mount Mansfield, say, officers of the law will show up to stop me.

This disparity is particularly strange, given that my medical credentials were issued and verified exclusively by national organizations. I passed the *United States Medical Licensing Examination*. I have been certified and recertified by *The American Board of Orthopedic Surgery*. Had I ever been found liable in a malpractice suit, that event would have been recorded in the *National Practitioner Data Bank*. Nevertheless, the *state* of Vermont limits the practice of medicine within its boundaries to those it has specifically authorized. This arrangement is inefficient and harmful to patients. It should be replaced.

I am not picking on Vermont, for every state has similar laws. I am also not advocating for the abolishment of medical licensure. While market forces alone may protect consumers of hair braiding services or floral arrangements (to the point that occupational licenses

in those fields might be "ridiculous" [2]), in health care, the stakes are high enough to justify high standards. Still, the current system is too restrictive.

Before the advent of national databases, it may have made sense to insist that physicians document their credentials in each and every state in which they wished to practice. Yet today, the sharing of a physician's complete history is a mouse-click away. A more modern approach would better exploit available technology.

In the system I envision, physicians applying to practice outside of their home state would share with the chosen states their credentials, as maintained by their home state's medical board (or perhaps a national organization devoted to this very purpose). If there were no areas of concern, the target state would give to the license granted in the originating state "full faith and credit" (to borrow the language of Article IV of the United States Constitution, addressing the states' obligations to recognize each other's proceedings). In each state that physicians have registered their licenses, they would pay a fractional licensing fee based on how much work they do in the given state, similar to the apportioned vehicle use charges levied on interstate truckers who drive across the country.

It would be reasonable to limit national license registration to those physicians who maintain board certification, who have a pristine record, and who are not subject to any pending disciplinary proceedings. Renewal of registration within a

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given state likewise would demand completion of the state's continuing-education requirements.

National license registration would unburden physicians, but more importantly, it would help patients. The most obvious benefit pertains to phone/video consultations (so-called telemedicine), allowing patients in remote areas to avail themselves of expertise at a distance. National license registration would also stimulate competition, which would increase the value patients receive. National physician registration may also produce new models of delivering care. For example, the surgeon who becomes proficient at operations whose infrequent indication makes them hard to master could tour the country and assist local surgeons, or perhaps conduct an independent itinerant practice herself. A national medical license registry may also make it easier for hospitals to arrange on-call coverage from *locum tenens* doctors, and in turn, relieve local providers and minimize their risk of burnout.

The newly formed Interstate Medical Licensure Compact (<https://imlcc.org/>), a product of the Federation of State Medical Boards and federal government subsidies, begins to address the issue, but does not go far enough. This compact makes it easier to obtain licenses from multiple states yet it only hints at a solution: One still needs 51 licenses to practice coast to coast. We need a bigger and better answer.

I am not a lawyer, but it seems to me that the federal government has the power to implement a bigger answer like national license registration, as it has already chipped away at some local licensing barriers. For one thing, federal law currently allows physicians to practice in a state without a local license, as long as care is offered within a Department of Veterans Affairs facility. The Sports Medicine Licensure Clarity



Fig. 1 An advertisement for the Philadelphia-based Rothman Institute, seen on the side of the M4 bus on Fifth Avenue, announcing the Institute's new office in New York City. Photo taken December 23, 2018. (Published with permission from Joseph Bernstein MD).

Act of 2017 also allows physicians to use their local medical licenses to treat athletes anywhere in the country, as long as they are acting as an official team physician [1]. In short, a national license registration system is within reach, if Congress were to insist on it.

I hope Congress takes action, but even without it, some progress is coming. This I learned on another recent family trip. Last December, strolling the streets of New York somewhere southeast of Rockefeller Center, I saw a bus go by, carrying the advertisement of a Philadelphia orthopaedic group (Fig. 1). Evidently, even without national license registration, physician groups can move—eventually. We need more of this.

Programs like national license registration that encourage the free flow of medical talent serve our patients and deserve our support.

Alexander R. Vaccaro MD, PhD, MBA

President

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Prior to beginning my commentary on the well-laid-out points put forth by Dr. Bernstein, I would like to make one

clarification regarding Dr. Bernstein's recent experience noticing a New York City bus with an advertisement for the Rothman Orthopaedic Institute. Although the Rothman Orthopaedic Institute will be expanding into the New York City healthcare market—"Rothman Orthopaedics of New York, PLLC"—this particular practice will be a limited liability company which will employ healthcare providers who are licensed in New York.

Dr. Bernstein makes some compelling arguments regarding the need for a National License Registration process so that physicians may more easily practice outside of their home state. He makes some strong points about how this approach could (1) improve access to care for patients (via telemedicine), (2) promote the dissemination of highly specialized health care by allowing specialists to administer care and teach to local providers, and (3) reduce the burden of physician shortages and subsequent provider burnout by expanding the available pool of *locum tenens* doctors.

As a physician who is licensed to practice in six states, I support Dr.

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Bernstein's proposal for this National License Registration process; however, I would take his proposal a step further. I believe a federally mandated registration process for medical licensing should be the only way physicians are licensed, as opposed to a supplementary option that physicians can choose to partake in based on individual goals. By removing individual state-licensing boards, I believe there would be a substantial increase in the accessibility of highly specialized medicine, which would benefit both patients and providers alike. As a correlate, this federal licensing board would also ensure only physicians with a verified safe medical history record would have the opportunity to practice medicine. Far too often, physicians who lose a medical license in one state can obtain another state license with relative ease and minimal oversight. This is problematic as unsuspecting patients could potentially be treated by an unfit physician.

Despite these potential benefits, establishing this sort of federal oversight would involve a reconciliation of the differences among state-specific licensing requirements. Perhaps a consolidation of the most-common questions posed to applicants in each of these individual, state-specific licensing proceedings could bypass this logistical issue.

A national license registration system proposed by Dr. Bernstein is an important concept that should be explored further. Allowing only competent, morally intact physicians to provide specialized care throughout the United States would promote teaching opportunities to smaller institutions, mitigate the risk of physician burnout, and ultimately expand access to high quality medical care for our patients.

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Dr. Bernstein argues that there is no reason to keep physicians from practicing across state lines. As he notes, medical credentials are not state-specific, and the benefits, in terms of allowing patients in remote areas access to care, stimulating competition, and allowing new models of delivering care, would be substantial.

Dr. Bernstein's proposal, however, would not eliminate the barriers to interstate telemedicine [4]. In his model, registration occurs at the state level, physicians pay a fractional licensing fee, and physicians must meet continuing medical education requirements that vary across states (only five states require no continuing medical education). Would physicians be held to the medical practice rules of their home state or would they have to abide by those in each of the states in which they practice? That would bring the plan perilously close to the current system in which physicians must be licensed in every state in which they practice.

In Dr. Bernstein's model, physicians share their credentials and "(i)f there were no areas of concern, the target state would give to the license granted in the originating state 'full faith and credit.'" Does this mean the states must go beyond credential verification to vet other information? That doesn't sound like "full faith and credit."

Dr. Bernstein wants to limit access to interstate practice to physicians who are specialty board certified. A concern is that this gives the medical specialty boards monopoly power over who can practice across state lines.

Like many others, Dr. Bernstein argues that market forces protect consumers but, when it comes to health care, the "stakes are high

enough to justify high standards." It is true the stakes are high, but state medical boards have a poor record when it comes to identifying malfeasant physicians [5]. Oversight comes from healthcare providers who are liable if things go wrong. This includes hospitals, physician groups, insurance companies that include physicians in their networks, and medical-liability insurers [5].

If we are to provide patients with additional information about physician quality, I believe we should require physicians to disclose whether they have medical professional liability insurance and if it includes any restrictions on their practices. Patients cared for by national telemedicine providers are protected by the providers' liability and concern for their reputations. But for sole practitioners, transparency in medical professional liability insurance would offer some assurance that of professional standards of care [3].

Opposition at the state level to interstate telemedicine by state medical boards precludes the type of cross-state recognition that one has with a driver's license. Alternatively, Congress could act to redefine the location of the practice of medicine. Now, states define it as the location of the patient, which is why doctors need to be licensed in so many states. Change it to the location of the physician and the problem is solved. Complaints would go to a physician's home state board, rather than being spread across multiple state boards. As cases reach the courts, jurisdiction would be assigned, most likely in the patient's state where the damage is alleged to have occurred.

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