Reducing Harm and Healthcare Costs: A Review Of A Physician's Unlimited License To Practice

Generally, physicians are licensed under what is termed an "unlimited" license. Underlying the intent of unlimited licensure is the expectation and requirement that physicians only provide those services for which they have received specific training and education. Unfortunately, there is no entity that can police or oversee that physicians adhere to the intent underlying the justification for unlimited licensure. As a result, unlimited licensure contributes to undue harm to patients, and is a public policy issue that needs to be addressed. There are few, if any, restrictions as to what they can practice under their scope of practice. With little risk of liability, physicians can incorporate into their practice whatever services that any other licensed healthcare professional provides. No other healthcare professional enjoys such protection in law. In fact, this concept was implemented at the turn of the last century, and is clearly out of date and out of touch with current knowledge. The justification for licensure of healthcare professionals is to protect the public. The justification by physicians for unlimited licensure was that rural America had so few physicians that they needed to provide a wide range of services, and limited licensure would result in patients being denied care. America no longer is an agrarian society, and unlimited licensure has not resulted in better patient care.

Psychologists, nurses, nurse practitioners and other healthcare professionals practice under what is termed a "limited" license. This means that these professionals can only practice what is stated in their scope of practice law. Typically, they can legally provide services that they have specific training, education and experience and that fall only into the categories of services that are specified in their practice law. The concept of limited licensing was designed to protect the public from practitioners who are not qualified to provide a specific service due to lack of training, education and experience. It is easy to see that limited licensing is a very good way to achieve this goal. The question is: Why are physicians granted this exception when it is clear that the lack of specific behavioral health training and education significantly contributes to ineffective treatment, runaway medical costs, and harm to patients?

The Federation of State Medical Boards

The Federation of State Medical Boards (FSMB) is a tax-exempt organization representing the 70 medical boards of the United States and its territories. The mission of the FSMB is "To continuously

improve the quality, safety and integrity of health care through developing and promoting high standards for physician licensure and practice."[192] The FSMB produced a study specifically relating to the problems inherent to the unlimited licensing of physicians. In its report, the FSMB concluded:

"While state licensure boards may establish a rigorous procedure for granting initial licensure, in virtually all states, it is possible for a physician to practice medicine for a lifetime without having to demonstrate to the state medical board that he or she has maintained an acceptable level of continuing qualifications or competence."[193]

Interestingly, in its response to the FSMB, the Association of American Physicians and Surgeons (AAPS) advocates that one way to improve the quality of care would be for physicians to employ evidence-based principles in diagnosing problems and prescribing remedies. [194,195] NAPPP agrees with the AAPS, and we would like to see this implemented particularly with respect to patients receiving treatment by primary care physicians for behavioral disorders.

The AAPS also addresses many of the concerns that NAPPP has with respect to the lack of behavioral health education and training with non-psychiatric physician care. They cite: 1) The general poor quality of medical school applicants; 2) The small amount of time that physicians have to devote to patients; 3) The shortage of American-trained physicians and the increased reliance on foreign-trained physicians with limited language skills. NAPPP agrees with all of these factors. In fact, these issues impact patients suffering from behavioral disorders more than any other malady. Behavioral disorders and their treatment require clear and specific training and intellect, clear communication, a clear knowledge of the patient's culture and a significant amount of time to be spent with the patient.

Moreover, for the past 15 years, psychiatry, as an example, has had to recruit foreign-born residents to fill their declining training slots. All of these issues are present in a primary care setting where only minutes can be provided to the patient by a physician with *little or no training in behavioral health*, who increasingly is foreign born and trained, who may possess limited language skills, and cultural understanding.

The Medical Home Model

The concept of the "medical home" model is one in which a primary care physician essentially is responsible for the overall health of a patient and arranges for the total needs of a patient to be met. This means getting the appropriate referrals to specialists and other healthcare professionals when necessary. Ideally, the model calls for many specialists and healthcare providers being housed under the same roof. The concept was initially formulated by the American Academy of Pediatrics (AAP) in 1967. In 2002, AAP issued a formal policy statement expanding the concept to include accessibility, continuity, and comprehensive, family-centered, coordinated, effective care. The American Academy of Family Physicians (AAFP) and the American College of Physicians (ACP) have issued statements, separate from the AAPS, on their own models for improving patient care. What is important about the medical home concept is that two of the guiding principles are based upon having physicians refer patients to an appropriate provider for treatment and employing evidence-based medicine to provide the best treatments available based on objective research.[195a]

No one could argue or disagree that the "medical home" concept has the potential for improving patient care and outcomes. The problems, as has been pointed out throughout this document, is that physicians have accepted the medicalization of behavioral healthcare, prescribing medications for mental, emotional, and behavioral conditions when the best data shows medications are the least effective. Most primary care physicians prescribe medications without an appropriate evaluation and diagnosis by a psychologist or psychiatrist. They prescribe medications off-label for conditions for which there are proven behavioral treatments. One of the more egregious and dangerous practices is prescribing antipyschotic medications for patients presenting with relatively simple sleep problems.

Moreover, if physicians were committed to employing evidence-based medicine, few, if any, would be prescribing antidepressants and the host of psychotropic medications now prescribed. The objective clinical data on these medications, at least those that are published and have not been suppressed by drug manufacturers, show that, on the whole they are not effective. Then there is the issue of expecting a primary care physician to be a supervisor not only of the patient's care, but also of the independently licensed professionals who provide treatments to patients.

In order to be an effective supervisor, as opposed to an administrator, primary care physicians would have to have specific knowledge of the presenting problem, but also know which provider and which treatment would be the safest and most effective for the patient. In our opinion, this is asking too much of primary care physicians. They would need specific education and training on when and to whom they should be referring a patient. This type of training, while fundamental in the training of psychologists and other healthcare professionals, is relatively absent from medical training and practice. Yes, primary care physicians know when to refer to a medical specialist, but they lack the knowledge base when a referral is needed to a healthcare provider outside of medicine. This is the rationale behind the medicalization of all health and health-related maladies. If there is a problem, the assumption is that it is a medical problem and there is a medical solution.

Physicians Are Not Trained To Review Drug Company Research

It has been widely reported that pharmaceutical companies many times will report only "positive" results of clinical trials concerning their products. They routinely will omit the non-findings or negative findings in which a new drug or procedure may have proved more harmful than helpful.[195b] The basic motivation for this practice clearly is the financial interests that pharmaceutical or medical device companies have when they are the source of a study's funding. For example, pharmaceutical maker GlaxoSmithKline suppressed and hid results from several clinical trials that not only failed to show treatment effectiveness for off-label use of its SSRI among children and teens, but also showed possible increased risk of suicidal tendencies in this age group.

Another example of how drug manufacturers fool physicians and the public can be seen with the drug Abilify. The antipsychotic drug Abilify is an FDA-approved medication for treating schizophrenia. The FDA later approved it to also treat mania and depression. Yet, the more important information about this drug is that there is no real scientific evidence that it contributes to any reduction in symptoms related to depression. Moreover, this is an antipsychotic medication that can cause death in the elderly who have dementia. It can also cause a significant and dangerous increase in blood sugar, resulting in both cardiovascular problems and diabetes.

Physicians rely upon these reports from drug companies to make important clinical decisions. The problem is that the average physician has little, if any, research experience or training in statistical methodology.[195c] As a result, physicians who lack this training accept bogus findings about the efficacy

of these drugs and prescribe them to patients. With respect to behavioral disorders, cases in which drug manufacturers apparently find it easier to suppress and manipulate negative data, these patients are put at high risks when prescribed many of these medications. In comparison, psychologists are trained in all aspects of research and statistics starting in undergraduate school all the way through their doctoral training. Using statistics to hide, manipulate or simply lie is easily detected by psychologists.

The practice of modern medicine centers on drug therapy. How many patients visit a physician and come away without a prescription? Not many, if at all. Given this reality, does it make any sense for physicians to have an unlimited license to prescribe when they cannot even demonstrate a working knowledge in how to detect statistical manipulation of the studies that they rely upon to prescribe these medications? We think not. Limited licensure can reduce many of the problems and risks due to faulty prescribing because physicians will have far less medications to learn about. Risks due to of-label prescribing will be reduced. Moreover, the expenditures for relatively worthless medications will decrease. Everyone is a winner with limited licensure: Physicians, the public, patients and taxpayers all gain.

The NAPPP Proposal

The remedy is simple: Medical licensure boards should subject physicians to the same limited licensing under which every other healthcare professional provides services. Physicians should only provide services when they can specifically demonstrate that they have had and passed the requisite education as determined by their respective medical and specialty boards. They should be limited to providing services only in their proven fields of specialization. This also means that physicians should be required to refer patients to qualified specialists both inside and outside of medicine. Limited licensing would require that physicians could not prescribe medications for conditions outside of their specialty. This would allow physicians to concentrate on the medications to treat conditions that they legally are able and licensed to treat.

Presently, any physician can prescribe any approved medication and can also prescribe medications for conditions for which the drugs are not FDA-approved. For example, we see many physicians prescribing harmful anti-psychotic medications such as Zyprexa and Seroquel to patients complaining of sleep interruption. These anti-psychotic medications have grave side-effects including significant weight gain, cardiovascular problems, diabetes and heavy sedation. When used to treat sleep disorders,

which even the FDA states are best handled by behavioral intervention, non-psychiatric physicians are exposing their patients to harm that far exceeds the benefits of sedation.

Limited licensing is not an intrusion on professional autonomy. Psychologists have worked under these restrictions since our inception as licensed providers. In fact, psychologists are the only healthcare practitioners who must determine that a patient's condition is not one that is physical in origin and, if it is physical, must be referred to a physician for treatment. Only after ascertaining that the patient does, in fact, present with a behavioral disorder, can we proceed to treat. We do not see this as an intrusion to our professional autonomy.

We accept limited licensure as a safeguard for patients and because it is the rational and ethical thing to do. We accept scope of practice limitations and seek legislative changes only when we can make the case that we are able to provide a new service and are qualified to do so. Yet primary care physicians are put in the untenable position where they must treat patients for behavioral disorders for which they have little or no training. This situation does not bode well for patient safety, and exposes primary care physicians to increased professional liability, a contributing factor to malpractice insurance and awards and increased healthcare costs.

One would think that primary care physicians would appreciate being relieved from the liability they are subjected to when treating patients with behavioral disorders. Yet organized medicine resists changes to scope of practice of other healthcare professionals under the guise of patient safety. This resistance is odd, because primary care physicians routinely prescribe medications for behavioral disorders without the necessary education and training for safe and successful outcomes. These patients are at risk, and pay a heavy price for the assertion that physicians have the ability to diagnose and treat any malady even though they do not have the expertise to do so. NAPPP believes that specially trained medical psychologists would provide this relief to physician colleagues by integrating behavioral health into primary care, resulting in physicians limiting their care to their specific expertise**.**

Professional Autonomy

Clearly, physicians go through a rigorous training process to obtain their initial medical degree. But so do other healthcare professionals. Professional autonomy is a concern for all of us. There must, however, be a balance between the patient's interest and professional autonomy. To subvert treatment

and ethical considerations because of economic issues, or the interests of corporations such as drug manufacturers and insurers, is not a balance. It is sabotage and represents a wholesale disregard for the reasons one enters healthcare. As consumers and providers, we are stakeholders and our concerns also must be heard. America has become a culture that is reactive to events only after disaster strikes. NAPPP believes that the deaths of more than 100,000 patients a year from medication errors qualifies as a disaster. We believe that we must be proactive. Following the concerns presented in the FSMB report is one way to produce a balanced remedy. Limiting scope of practice to areas of expertise developed through education, training, and experience is another and, in our opinion, an additional option.

Yes, a license is an intellectual property right and should be protected. Nevertheless, a license is a state-authorized privilege that can be changed. This privilege can be properly taken or modified, as long as there is a process safeguarded in law. It is unacceptable for physicians to resist and fight against a limited license while at the same time advocating for malpractice reform that limits their liability for negligence. This is a prime example of wanting to have one's cake and it eat it, too. Quality and safety are improved by stated limitations. Competition also can improve quality and decrease overall healthcare costs. Organized medicine needs to become part of the solution and not remain a major part of the problems plaguing healthcare.

Concluding Statement

There is evidence that physicians practicing outside their education and training contributes to a system in which patients are not being appropriately served and are being subjected to undue harm. Limited licensure of all healthcare providers to practice within the scope of their education and training can improve competence, treatment outcomes, and greatly decrease the cost of healthcare while raising the standard of care provided to patients.