

Commentary: Granting Medical Licensure, Honoring the Americans With Disabilities Act, and Protecting the Public: Can We Do All Three?

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Abstract

Physicians suffer from the same illnesses as others do, and some of these illnesses may limit their ability to safely practice medicine. Individuals with some of these same illnesses may also suffer from denial, blinding them to their limitations. Data support that, while many of these physicians do voluntarily limit their practices or seek help, not all do. Schroeder and colleagues demonstrate in this issue that in their attempts to protect the public, state medical licensing boards may have asked questions prohibited by the Americans with Disabilities Act. They point out an ethical

tension between nonmaleficence (protecting the public from harm) and individual autonomy (respecting the rights of each individual physician), amplified by the different approaches lawyers and physicians use to address conflicts. The classic legal approach is adversarial, whereas the classic medical approach is collaborative. Both are valid approaches, but neither works well in tandem with the other. The time has come for all sides of the licensure debate to acknowledge the legitimacy of the others' concerns, to recognize the different approaches they each take, and

to work together with others to find a common solution. The solution must allow boards to identify individuals with illnesses that impair their ability to practice safely and that also lead to denial of these very limitations. The solution must respect the autonomy of the individual licensee with a disability who can practice safely with an accommodation and who respects the need for that accommodation. The solution must protect the public.

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Editor's Note: This is a commentary on Schroeder R, Brazeau CMLR, Zackin F, et al. Do state medical board applications violate the Americans with Disabilities Act? Acad Med. 2009;84:776–781.

Documented licensure of physicians began in the early 13th century, when the faculty at Salerno first began issuing physicians practice licenses.¹ In 1873, Texas passed the first modern medical practice act requiring that all practicing physicians be licensed by the state.² From that time forward, state medical licensing boards have faced diverse challenges and pressures. Historically, medicine is a profession, a calling requiring specialized knowledge and often lengthy training. Professions in this sense are traditionally self-regulating and dedicated to the service of others. As described by Roscoe Pound,³ dean of Harvard Law School, "The term [professionalism] refers to a group pursuing a learned art as a

common calling in the spirit of public service—no less a public service because it may incidentally be a means of livelihood. Pursuit of the learned art in the spirit of a public service is the primary purpose." Today, state medical boards are responsible for licensing physicians, in this way providing regulation within the profession.

Medical boards are regulatory bodies of the state or territorial government, typically of the executive branch. In this form, they serve to protect the welfare of the citizens. As agencies of the state government, licensing boards are not fully independent bodies. Their power derives from the authority granted to them by law, typically the Medical Practice Act. Through this act, boards are typically charged with fulfilling the following ideals:

1. The practice of medicine is a privilege granted by the people acting through their elected representatives. It is not a natural right of individuals.
2. In the interests of public health, safety, and welfare, and to protect the public from the unprofessional, improper, incompetent, unlawful, fraudulent, and/or deceptive practice of medicine, it is necessary to provide laws and

regulations to govern the granting and subsequent use of the privilege to practice medicine.

3. The primary responsibility and obligation of the state medical board is to protect the public.⁴

Virtually all practice acts include language similar to this.

In function, medical boards typically are reactive agencies. They respond to complaints about practitioners, but they do not conduct proactive investigations. Boards rarely go out and set "stings" to trap physicians. For a variety of reasons, it is only when a problem has already occurred, when a patient is aggrieved or harmed, that a board intervenes.

We would like to believe all physicians always act in accordance with Dr. William J. Mayo's exhortation at the 1910 graduation of Rush Medical College: "The best interest of the patient is the only interest to be considered." This is important, for as is true of many professions, we have unique rights and responsibilities as physicians. We are allowed to ask questions about the most intimate details of a patient's life, details patients often do not even share with their partners. We have the right to touch

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Medicine Versus Law: How Can We Help Everyone Win?

Whenever there is an ethical tension, the solution becomes complicated. Almost never do we find a simple "right answer." There are extremes to addressing this specific tension. One extreme is for boards to avoid overstepping ADA bounds by making no inquiries about health and only responding to complaints. This does not protect the public. The other extreme is for boards to question physicians aggressively about their health to uncover any potential red flags. This does not respect the rights of physicians with disabilities.

This tension is amplified by the historic difference in how the fields of law and medicine resolve disputes. The classic legal model is the advocate model, where an advocate for each side aggressively argues his or her point of view. From the tension between these two sides, justice may emerge. The classic medical model is collaboration, where all parties discuss their perspectives back and forth and, from these discussions, the right answer may emerge. Each model has benefits and drawbacks, and each may be more effective in certain situations. The practical difficulty occurs when we try to solve problems by using both models simultaneously. It does not work.

Resolving the tension between protecting the public and protecting the rights of impaired individuals requires Solomonic wisdom. The time has come for all sides of this argument to begin to work

together in collaboration. To do so, both sides will need to acknowledge that the other has legitimate concerns and interests. Solutions must be found that allow boards to identify individuals with impairments that limit their ability to practice safely. These solutions must recognize that these individuals may be in denial of their limitations and may not voluntarily report them. However, solutions must not unduly burden individuals with disabilities who can practice safely. Attempts to advocate on behalf of one side without respecting the legitimate needs and concerns of the other will only result in resistance and conflict.

If all sides collaborate and share knowledge, they will come to a better solution and be willing to act on the solution.¹¹ The classic adversarial model has a winner and a loser. For us to address all the concerns, all sides need to believe their concerns are understood and appreciated and that no one loses. The legal community does use this technique, in mediation. The time has come for all sides to step back and decide how, together, we can address the concerns. All sides must acknowledge that others have valid concerns. All sides must agree that if the concerns are valid, we need a solution that addresses all the concerns and that we do not have "winners" and "losers." All sides must acknowledge that there may be strong feelings present but that we can have strong feelings without impugning the motives of each other. Working together, we can find solutions

that will be better for all—the public, our patients, and our professions.

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