# The Physician's License: An Achilles Heel?

Henry Mark Holzer, J.D.

*Henry Mark Holzer, Professor of Law at Brooklyn Law School and a constitutional litigator, currently represents physician groups in Massachusetts and West Virginia.*

Reprinted from The Journal of Legal Medicine, Vol. 12, pp. 201 - 220, 1991, by permission of Hemisphere Publishing Corporation, a member of the Taylor and Frances Group.

## Introduction

Greek legend tells of Achilles, foremost of the Trojan War heroes, who was brought down by an arrow that struck his one vulnerable spot. There is a modern-day parallel, making physicians practicing in the United States today vulnerable to the power of the government in a way that few have noticed. Through each state's abuse of the power over medical licenses, private physicians may be made virtual servants to state-perceived medical care needs. Today, those needs transcend caring simply for the elderly, indigent, and other customary beneficiaries of state-provided health care services -- by far.

News travels fast in a small town, and so the man who needed hernia surgery declined to be tested for acquired immunodeficiency syndrome virus. The hospital ran the test anyway, and allegedly the results became common knowledge among the physicians of the hospital, the only one in the county serving the low-income population. No one would operate on the man. They told him to seek surgery in San Francisco, several hours to the south.

"We get phone calls like this from patients around the country," says Norman Nickens, coordinator of the Lesbian/Gay/AIDS Unit of the Human Rights Commission of the City and County of San Francisco. "I just got a call from someone in West Virginia who could not find a local doctor to see him." The evidence is now overwhelming that government at all levels, in an attempt to fulfill the role of self-appointed guarantor of the well-being of its citizens, insists on more and more health care for an ever-increasing pool of beneficiaries. Because of antidiscrimination statutes and interpretations of medical ethics, those beneficiaries now include HIV-positive patients. Concomitantly, there is a decreasing public ability to finance, and a diminishing professional willingness to provide, that care.

## I. Health Costs and America's Physicians

At the beginning of 1990, the Bipartisan Commission on Comprehensive Health Care, created two years earlier by Congress to recommend legislation on health care issues, issued a report calling for an $86.2 billion program that would provide not only health insurance to each and every American who needed it, but long-term nursing care as well. (One remembers the early estimates of how much it was going to cost the American taxpayer to fund the Savings & Loan bailout.) This $86.2 billion was not the program's cost for a decade nor even for several years. The $86.2 billion price tag was estimated at the requisite funding for just a single year. The total Federal share of the health insurance and nursing homes programs was to cost $66.2 billion a year. Expanded nursing home care for elderly people with low and moderate incomes for others with severe disabilities would take $42.8 billion of the $66.2 billion. "The remaining $23.4 billion in Federal money would provide health insurance for those who do not already have it."

Approved by the Commission by a narrow margin, Representative Fortney H. Stark, D-Cal., candidly admitted that "[w]ithout a way to pay for it, [the idea] is a non-starter. ... It is legislatively dead." Even the

Commission's Chairman, Senator John D. Rockefeller IV, recognized that "[w]e are not dealing with the world's easiest problem." To put it mildly! Lacking are both material and human resources, a problem universally recognized.

In an article that appeared in the New York Times in early 1990, focusing on the Massachusetts experience, it was observed that as much as physicians in 49 states may complain about how much they are regulated, it could be worse. They could be working in Massachusetts, where regulation of practices and fees are the most extensive in the country. But that degree of regulation is not without cost. The Times noted further:

The American Medical Association estimates that more than 10 percent of doctors in private practice have left the state since 1985; the figure may be as high as 30 percent in some specialties, although a special state commission says the figures are difficult to determine. ... Last year Massachusetts convened a special Physician Supply Commission to study the problem. That was in part to respond to legislators' claims that constituents in some areas were having trouble finding physicians and to claims by hospitals in some parts of the state that they could not fill their staffs. ...

Massachusetts is not alone in trying to provide the maximum amount of health care for the least amount of money. Another current example is West Virginia, where the state pays the health care costs of virtually all of its public employees. Caught in the same bind as Massachusetts and other states -- with commitments to provide health care vastly outstripping actual and potential funding through taxation -- West Virginia shifted a substantial portion of its health care costs to the shoulders of the states' physicians. Not only did West Virginia enact a law, like Massachusetts, against "balance billing," but it went even further in an effort to provide as much medical care for as many people at the least possible cost to the state.

A close examination of the West Virginia legislation offers a meaningful insight into the nature of the threat that American physicians now face through their licenses. The Omnibus Health Care Cost Containment Act was born in the Office of the Governor, with identical versions being submitted virtually simultaneously to the House and Senate. The House bill (H.B. 2707) was introduced on March 21, 1989 and immediately referred to the Finance Committee. The bill was never considered thereafter by the Finance Committee, and the House bill went nowhere.

The Senate version, S.B. 576, eventually became law. Filed "By Request of the Executive," on March 20, 1989, the bill cleared both Houses of the West Virginia legislature in about one month and was promptly signed into law. As a statement of public policy, certain legislative "Findings" were incorporated into the statute, virtually replicating the Governor's rationale for adopting the legislation. The legislative findings and purposes are set forth below:

(1) That a significant and ever-increasing amount of the state's financial resources are required to assure that the citizens of the state who are reliant on the state for the provision of health care services and payment thereof receive such, whether through the public employees insurance agency, the state medicaid program, the workers' compensation fund, the division of rehabilitation services or otherwise;

(2) That the state has been unable to timely pay for such health care services;

(3) That the public employees insurance agency and the state medicaid program face serious financial difficulties in terms of decreasing amounts of available federal or state dollars by which to fund their respective programs and in paying debts presently owed;

(4) That, in order to alleviate such situation and to assure such health care services, in addition to adequate funding of such programs, the state must effect cost savings in the provision of such health care;

(5) That it is in the best interest of the state and the citizens thereof that the various state departments and divisions, involved in such provisions of health care and the payment thereof cooperate in the effecting of cost savings; and

(6) That the health and well-being of all state citizens,

and particularly those whose health care is provided or paid for by the public employees insurance agency, the state medicaid program, the workers' compensation fund and the division of rehabilitation services, are of primary concern to the state.

(b) This article is enacted to provide a framework within which the departments and divisions of state government can cooperate to effect cost savings for the provision of health care services and the payment thereof. It is the purpose of the Legislature to encourage the long-term, well-planned development of fair, equitable and cost-effective systems for all health care providers paid or reimbursed by the public employees insurance agency, the state medicaid program, the workers' compensation fund or the division of rehabilitation services.

This statement of legislative purpose clearly indicates that the raison d'etre for West Virginia's Omnibus Health Care Cost Containment Act was to shift part of the cost of medical care from the state to someone else. Basically, there were two candidates -- the taxpayers generally, or physicians in particular. In this regard, the legislative history contains a "smoking gun."

Although in the House Finance Committee no transcript of the proceedings is made, a staffer takes notes. On April 4, 1989, S.B. 576 was referred to subcommittee, and the next day the bill was discussed in the full committee. There, a witness named Phil Reale, representing the Governor, conceded, as the "Findings" quoted above make quite clear, that S.B. 576 was actually a budget bill: "[T]axes can't be raised again to take care of the problem."

West Virginia tried to solve its "problem" in three ways:

1. By allowing state agencies that provide health insurance coverage to "cap" payments to health care providers for services rendered to the formers' beneficiaries. In other words, when the state paid its employees' medical bills, the physicians would receive pre-set amounts. There would be no sums paid in excess of what the state "schedule" provided.

2. By prohibiting "balance billing." No matter how much the physician believed his or her services to be worth, no matter the ability and willingness of the patient to pay, the state's payment was all that the health care provider could receive.

3. A so-called "take-one-take-all" provision was enacted, requiring that the providing of services to any one state beneficiary necessitates the providing of services either to every other one who wants medical care, or to a certain number of Medicaid patients (probably 15% of the physician's total patients). This means that a West Virginia physician was given the choice of either refusing to see many patients or, in order to continue treating them, accepting as patients an unlimited number of state medical care beneficiaries.

In sum, West Virginia has placed the state's physicians in a vise. Having undertaken to pay the medical bills of thousands of state employees who are the patients of private physicians, West Virginia has substantial power over those health care providers. Through the use of the three means just discussed, the state has used that power to purchase low-cost medical care at the physicians' expense.

## II. The Physician's Achilles Heel

As clever as the West Virginia Legislature may have been in shifting to the shoulders of the states' physicians much of its self-imposed burden to provide health care for virtually all of its public employees, an even more Machiavellian scheme has been hatched, predictably, by Massachusetts. There, the legislature has implemented a sure-fire device through which that state -- and any other state -- can satisfy much of its self-chosen commitment to provide near-universal health care not only at a reduced or low cost, but perhaps even at no cost at all.

The device involves tying the physician's license to practice medicine to a personal obligation to serve state-designated health care beneficiaries. In other words, as a condition of practicing medicine, the physician must serve the needs of those selected by the state, at a price determined not by the physician and the patient, but by the state.

The story of how "license servitude" became law in Massachusetts, and the response of Worcester's distinguished internist Dr. Leonard J. Morse, has an important bearing on not only the problem confronting the nation's physicians, but on its solution. In a 1986 article appearing in Massachusetts Medicine, Dr. Morse explained that, as a condition of granting or renewing a license, the 1986 statute prohibited physicians who accepted Medicare from "balance billing." In other words, Medicare assignment was to be mandatory.

This was not a new idea in Massachusetts. Two years earlier, the Board of Registration in Medicine, of which Dr. Morse was then Secretary, had been lobbied to make mandatory Medicare assignment a condition of licensure. The Board rejected the idea, and the legislation was proposed soon thereafter.

Dr. Morse provides an insider's view of how the Massachusetts Legislature was lobbied.

The atmosphere at the Health Care Committee hearing was overwhelmingly supportive ... Senior citizens were transported to Springfield for a day's excursion, and two television stations covering the hearing remained until the late morning, documenting only the proponent's testimony. Viewers of the evening news saw only one side of the issue, because opponents were not heard until late in the hearing.

Also lobbied was the Massachusetts Medical Society, whose 204th annual meeting was actually disrupted by members of the Massachusetts Senior Action Counsel and the Cape Cod Alliance for the Elderly, in support of the legislation.

The lobbying succeeded, making every Massachusetts physicians' license subject to mandatory Medicare assignment. Expressing the feelings of many Massachusetts physicians, Dr. Morse's article in Massachusetts Medicine concluded by indignantly stating that "as a practicing physician in Worcester for the past 24 years, I consider the passage of mandatory Medicare assignment a travesty of Justice and an affront to a noble profession."

Dr. Morse's final words explained the rationale for the stand he had taken:

I could not in good conscience continue to participate as a member of the Massachusetts Board of Registration in Medicine, despite the fact that I considered my appointment to the Board an honor, giving me the privilege to serve not only the citizens of our state, but the members of a dedicated profession.

Dr. Morse's principled stand squarely framed the issue. Like West Virginia, Massachusetts had sought to satisfy lobby-demanded, state-perceived health care needs by shifting the government's cost burden not to taxpayers in general, but to physicians in particular. Unlike West Virginia, however, or any other state so far, Massachusetts had backed-up that shift with a threat to the physicians's license.

## A. The Law of Professional Licensing

To understand fully the meaning and implications of the Massachusetts license servitude law, it is necessary to review the constitutional foundation upon which professional licensing laws rest.

Medical licensure laws were originally enacted in the United States during the late 19th and early 20th centuries as a matter of public necessity. Protecting the public against quackery, commercial exploitation,deception, and professional incompetence required legally enforceable standards for entrance into and continuation in the medical profession. The states' medical practice acts therefore specified both ethical and educational requirements for physicians -- requirements relating to personal character, scientific education, and practical training or experience.

The early licensure statutes reflected the recommendations of the Flexner Report on medical education published in 1910. This report initiated efforts to raise the standards of medical school admission, instruction, and curriculum, to place these schools under the jurisdiction of universities, and to provide full-time faculty and adequate facilities for teaching and clinical experience. The incorporation in medical licensure laws

of requirements which proprietary schools could not meet resulted in the closing of "diploma mills," as the inadequate medical schools of the time were called.

Ironically, the seminal precedent sustaining the constitutionality of state professional licensing laws was established in a case originating in West Virginia.

In 1882, the state had enacted a law requiring every medical practitioner to obtain a certificate from the state board of health attesting that the applicant had graduated from a "reputable" medical college or, alternatively, had practiced medicine continuously in West Virginia for 10 years prior to March 8, 1881, or "that he has been found, upon examination by the board, to be qualified to practice medicine in all its departments."

The "practice of, or the attempt by any person to practice, medicine, surgery, or obstetrics in the state without such certificate ... [was] a misdemeanor punishable by fine or imprisonment, or both, in the discretion of the court."

In the case of Dent v. West Virginia, the defendant was indicted under this West Virginia statute for unlawfully practicing medicine. He pleaded not guilty, and the prosecution and defense agreed to the following facts.

[T]he defendant was engaged in the practice of medicine ... at the time charged in the indictment, and had been so engaged since the year 1876 continuously to the present time, and has during all said time enjoyed a lucrative practice, publicly professing to be a physician, prescribing for the sick, and appending to his name the letters, "M.D.;" that he was not then and there a physician ... that he has no certificate, as required by [the law] but has a diploma from the "American Medical Eclectic College of Cincinnati, Ohio;" that he presented said diploma to the members of the board of health [but they refused to grant him the certificate] because, as they claimed, said college did not come under the word "reputable," as defined by said board of health; that if the defendant ... should be prevented from practicing medicine it would be a great injury to him, as it would deprive him of his only means of supporting himself and his family.

Dent claimed that the statute was unconstitutional because it interfered with his vested right to practice medicine. The trial judge rejected this argument and Dent was convicted.

Eventually, the case reached the Supreme Court of the United States, which enunciated legal principles that have informed the subject of professional licensing from that day to this. Rooting its decision in the state's power to provide for the general welfare of its citizens, especially securing them "against the consequences of ignorance and incapacity, as well as of deception and fraud,"the court upheld the West Virginia law. It emphasized that the state had a right to be concerned with the putative physician's skill and learning, and knowledge of such things as "the remedial properties of vegetable and mineral substances."

As the Court said in closing: "[T]he law of West Virginia was intended to secure such skill and learning in the profession of medicine that the community might trust with confidence those receiving a license under authority of the state."

That Dent stands for the proposition that states have the power to license professions in the public interest, and that the state's interest is in protecting its citizens from unskilled practitioners, is not open to doubt. Nor is it open to doubt that until Massachusetts went looking for a way to save itself health care money, the Dent principle, for the most part, had been interpreted to limit licensure criteria to those associated, either directly or indirectly, with skill and learning.

In modern times, this proposition was underscored by the Supreme Court of the United States in Schware v. Board of Law Examiners, where Justice Black equated "good moral character of proficiency" with "high standards of qualification." In other words, the tenth amendment to the Constitution of the United States reserved to the states the power to legislate in furtherance of health, safety, welfare, and morals, and the states have exercised that power by, among other things, requiring that medical licensees, and other professionals as well, be qualified -- that they demonstrate a sufficient level of knowledge and skill so that their patients may act in reliance thereon, thereby

reducing the potential that patients would be injured by quacks.

## B. The Challenge to Massachusetts License Servitude

Putting aside the important question of whether the state's imprimatur on a professional's skill and learning, let alone his or her moral fitness, is the best way to protect the public from incompetents, the qualification criteria traditionally has been the only requirement imposed on the medical license. Thus, prior to the two Massachusetts cases discussed below, derision and/or incredulity probably would have greeted the suggestion that an architect's licensing board could require that architects draw blueprints for a low-cost housing project, free of charge. Or that a plumber's licensing board could require plumbers to install pipes and fixtures, free of charge. Or that licensed undertakers bury the indigent without cost. Or that licensed bowling alleys provide free frames. Or licensed liquor stores free wine.

Similarly, it would have appeared unimaginable that all physicians in Massachusetts who treated federal Medicare patients could be required, under penalty of losing their state licenses, to accept as the fee for services rendered only what Medicare reimbursement provided, and not a nickel more, regardless of the patients' ability and willingness to pay. But that is exactly what Massachusetts has done, and the significance far transcends what has happened in the Bay State.

As Dr. Morse's resignation noted, Chapter 475 of the Massachusetts Act of 1985 now provides that the state licensing authority, the Board of Registration in Medicine, shall require as a condition of granting or renewing a physician's certificate of registration, that the physician, who if he agrees to treat a beneficiary of health insurance under Title XVIII of the Social Security Act, shall also agree not to charge to or collect from such beneficiary any amount in excess of the reasonable charge for that service as determined by the United States Secretary of Health and Human Services.

In other words, if a Massachusetts physician treats a patient over 65 years of age, the physician receives what the Medicare schedule allows for that housecall or procedure, or whatever, regardless of the physician's needs, regardless of the patient's ability and willingness to pay, and regardless of whatever mutually agreeable arrangements the physician and a patient otherwise may have made.

Not surprisingly, the license servitude statute was challenged in the United States District Court for the District of Massachusetts by the Massachusetts Medical Society and the American Medical Association. The case was entitled Massachusetts Medical Society v. Dukakis. To understand the court's decision, it is first necessary to highlight important aspects of the federal Medicare system. Under Medicare, physicians receive payment for the medical services that they provide on the basis of a "reasonable charge" established by the Department of Health and Human Services (HHS). Eighty percent of that "reasonable charge" is paid by the Medicare program, and the patient is obligated, at least in theory, to pay the balance of the physician's charge. Actually, the federal act contemplates either of two methods of payment. First, the physician can agree to accept what is referred to as "assignment" -- meaning that the physician will take as payment in full, no matter what the patient owes, the "reasonable amount" that HHS has established, 80% of that charge payable by Medicare and the remaining 20% payable by the patient. Or the physician can bill the patient directly for the services provided. The patient is then reimbursed by Medicare for 80% of the "reasonable charge." Obviously, the physician's actual charge to the patient can be more than the "reasonable charge," in which case the patient is personally responsible for (a) the remaining 20% of the "reasonable charge" and (b) however much more the physician has billed over the "reasonable charge." "The physician practice of charging an amount greater than the reasonable charge is called 'balance billing.'"

It is in this context that the Massachusetts license servitude law needs to be understood. As a prerequisite to obtaining or keeping a license to practice medicine in the state, the Massachusetts statute prohibited balance billing, forcing the physicians to take Medicare

assignment and to collect 100% of what HHS determines is a "reasonable charge." This "reasonable charge" may be far less than what the medical service is worth, far less than what the physician wants, far less than what the patient is able to pay, and far less than what the physician and patient would have voluntarily arranged between themselves had they been free to do so.

The Massachusetts Medical Society (MMS) and the American Medical Association (AMA) understood this point very well. In their federal court attack on the constitutionality of mandatory Medicare assignment, the core of their argument was articulated as follows:

Chapter 475 is ... unconstitutional because it violates the due process clause of the Fourteenth Amendment. This clause requires that any condition on professional licensure "must have a rational connection with the applicant's fitness or capacity to practice ... It forbids any condition that is not directed to protecting "against the consequences of ignorance and incapacity" or "deception and fraud."

In elaborating upon this point, the MMS and the AMA contended that the statute clearly imposed a condition on the license, but one that had no relation either to competence or character. But what about the cases cited by the Commonwealth in support of its core argument that the mandatory assignment condition on the license advanced certain legitimate governmental policies? The MMS and the AMA were able to distinguish some and turn others to their advantage.

For example, the MMS and the AMA noted that Nebbia v. New York was an economic regulation case that in no way implicated the requirement of competence to practice a profession. Other of the Commonwealth's cases were similarly distinguished as either not involving professional licensing or ultimately resting on the requirement of competency. According to the MMS and the AMA, not only did the Commonwealth's United States Supreme Court citations provide no support for the constitutionality of Massachusetts' mandatory assignment license condition, but neither did the four Massachusetts cases upon which the Commonwealth relied.

The MMS's and the AMA's last major point was an important one -- because the right to pursue a learned calling has always been recognized as more "protectable" than engaging in trade or business activities, social goals that limit the former must be more important than those that inhibit the latter. That being so, the MMS and the AMA observed that the Commonwealth had made no connection between the mandatory assignment condition on the license and the Massachusetts physicians' competence to practice medicine.

Substantively, the plaintiffs had lucidly defined the issue, and their constitutional arguments were cogent and compelling -- but to no avail. Despite these arguments, the United States district judge decided that the mandatory Medicare assignment condition was constitutional. Let us examine the court's reasons.

At the very beginning of that portion of the district court's opinion dealing with the license servitude issue, the judge succinctly stated the positions of each party: the MMS and the AMA were arguing that "[i]n order to pass constitutional muster ... the Act must bear a rational relationship to a physician's 'fitness or capacity to practice.' Defendants disagree that this is the appropriate standard, arguing that it is necessary only for the Act to bear a rational relationship to a legitimate state purpose." Obviously, the latter standard was very much broader, and thus considerably easier for the State of Massachusetts to satisfy.

After considering various precedential decisions of the United States Supreme Court and elsewhere, the court seemed to be drifting in the state's direction:

[I]t may be that the defendants' proposed "rational relation to a legitimate purpose" standard is the correct one. If this is so the Act must be upheld. The containment of medical costs for the elderly is plainly a legitimate concern of the Commonwealth. It is also plain that the legislature could reasonably determine that requiring physicians not to balance bill their Medicare patients was a means of addressing that concern, and that the licensure process was an effective mechanism for enforcing that prohibition. I conclude that the reliance of the legislature on the legislative facts that

medical care costs are a serious problem for the elderly and that conditions on licensure are an effective means of obtaining physician compliance with state regulation is well within the bounds of rationality required by ordinary due process scrutiny.

In other words -- and this is the least remarkable aspect of the decision -- if the test for assessing the constitutionality of Massachusetts' mandatory Medicare assignment was a rational relation to a legitimate purpose, as the state argued, rather than grounded in fitness or capacity to practice, as the MMS and AMA argued, the Act passed constitutional muster because helping the elderly with their medical bills is a worthy goal.

The more remarkable aspect of the court's decision, however, was what followed. What if the MMS and the AMA were correct? What if the appropriate test to be applied to the Act was not mere rational relation to a legitimate purpose (that is, helping the elderly with their medical bills), but rather whether the Act had a rational relation to a physician's fitness or capacity to practice? The court held that it would not make any difference. Even if rational relation to fitness or capacity was the proper standard, the constitutional challenge must fall.

In other words, even if the conditions imposed on a physician's license must be related to fitness or capacity to practice, including the traditional criteria of education, experience, and good moral character, mandatory Medicare assignment is sufficiently so related.

It was, of course, one thing for the district judge simply to assert this startling conclusion, but another for him to offer any support for it. What follows may seem to be an unduly lengthy quotation, but it is offered because four paragraphs constitute virtually everything that the judge had to say to buttress a decision that not only imposed a significant servitude on the physicians of Massachusetts, but opened the door to endless other servitudes on them and on their medical colleagues throughout the United States.

Nothing in the case law of conditions on professional licensure attributes to "fitness or capacity to practice law" the narrow definition advocated by [the MMS and the AMA]. Nor would such a definition ... be consistent with the broad powers which states hold to determine for themselves how best to promote the welfare of their people. Even if, under the Due Process Clause, a state may only require of a licensee that which is related to fitness or capacity, it must be sure that the state has some latitude in choosing what it considers to be necessary indications of fitness and capacity. However narrow or broad that latitude may be, I conclude that the power to require those licensees who choose to treat a particularly needy segment of the population to do so for limited fees lies within that latitude. Stated another way, I conclude that the legislature's determination as a matter of legislative fact that the provision of cost-contained services to the elderly is a necessary part of what it means to be fit and capable to practice in this state is not outside the bounds of what the Due Process Clause permits.

A strong analogy to that legislative choice lies in the requirement that lawyers serve some clients at little or no charge. The requirement to perform "pro bono" work or to accept without compensation a court-appointment to represent a needy client has been upheld numerous times by various courts.

[The MMS and the AMA] distinguish this line of cases by pointing out that lawyers have unique responsibilities as "officers of the court." But in this context, I conclude that this distinction between lawyers and physicians is without significance ... As are lawyers, doctors are entrusted with the performance of a special role. As do lawyers, they "enjoy a 'broad monopoly ... to do things other citizens may not lawfully do.'" As with lawyers, the state has a special interest in protecting its citizens by regulating those who fill that monopolistic role.

In sum, I conclude that the choice of the state legislature to designate the provision of cost-contained services to the elderly as a condition of licensure does not offend the Due Process Clause, even if that clause requires that such conditions reasonably relate to fitness or capacity to practice. The essence of the court's conclusion is startling, transcending even the license servitude issue that was being decided. In effect, the United States District Court for the District of Massachusetts was deciding that: because physicians receive a "monopoly"

from the state to practice medicine, they can be made to perform any service required of them by the state; performance of that service can be made an encumbrance on their licenses; and their failure to perform that service manifests unfitness and lack of capacity to practice medicine. In other words, with the license to practice medicine comes the duty to serve state-dictated goals. Today that means caring for the needy. Tomorrow, who knows?

## C. Pressing the Challenge to License Servitude

Undeterred, the MMS and the AMA appealed the district court's ruling to the United States Court of Appeals for the First Circuit. Although they did not challenge the underlying altruist, collectivist, statist principles that underlay the district court's decision, they did continue to hammer away at the idea that anything but fitness was the criterion for medical licensure, let alone that fitness included the willingness to serve the needy.

In the United States Court of Appeals, the MMS and the AMA tracked the arguments that they had made in the district court: although statutes regulating mere occupations can be upheld if they have a rational relation to a legitimate state interest, laws creating licensing conditions must be justified on the basis of fitness or capacity. The plaintiffs also added a powerful critique of the lower court's opinion upholding the constitutionality of mandatory Medicare assignment. The district judge erred, they contended, in several important respects. First, he was mistaken about mandatory assignment's alleged social goal of regulating fees to the needy because Medicare is not a need-based program but rather a program for the elderly of whatever means. Second, he was equally mistaken in attempting to rely on cases that have upheld the requirement that lawyers provide pro bono representation to indigent criminal defendants, because physicians can not be analogized to officers of the court and because the medical needs of elderly patients are not analogous to the constitutional rights of criminal defendants. The court of appeals disagreed.

MMS ... argues that the Massachusetts ban on balance billing violates the due process clause of the fourteenth amendment because it deprives doctors of the "liberty" to practice their profession. The Massachusetts statute makes a doctor's promise not to balance bill a condition of obtaining a license. ... Moreover, the Massachusetts Board of Registration in Medicine has stated that it will impose sanctions for any violation of the law "that are commensurate with the severity of the violation" ... -- sanctions that may include a reprimand, censure, fine, or suspension or revocation of license.*** MMS argues that the condition that Massachusetts imposes on medical licenses -- a promise not to balance bill is not rationally connected with a doctor's "fitness or capacity to practice" medicine.

In our view, however, this "promise" simply amounts to a rule. It is a rule that forbids balance billing. And, there is nothing irrational about a state's saying that a physician, entering the profession, must promise to follow the rules. Nor is it irrational to say that a physician who seriously violates the rule -- who commits a violation that is "commensurate with" the penalty of license revocation -- is not "fit" to practice medicine. For these reasons, the judgment of the district court is Affirmed. The court of appeals simply held that the "condition" not to balance bill was a mere "rule," and that rules had to be followed. Nothing more was offered by the court of appeals to justify its decision. "Rules" are "rules," no more, no less.

The MMS and the AMA arguments in the federal appellate court were well reasoned, as they had been in the district court, and based on solid consitutional principles. Skill and learning -- "fitness," if you like -- traditionally had been the sole criteria for granting and renewing a license to practice medicine, and for good reason -- to protect the patient from quacks. Yet, the political organs of the Massachusetts government (the legislature and the governor), and now both the federal trial and appellate the courts in that state, had decided that fitness alone was no longer enough. Thus, protecting patients was not all that the state, in its magnanimity, could do for them. Other patient-oriented goals could be accomplished by holding hostage the physician's license to practice medicine. In sum, the patient's needs -- this time, for less costly medical care

-- could and should be satisfied at the expense of the physician.

But if that were true -- if the physician's license to practice medicine was to be held hostage to the financial needs of the patient -- then to what could that license not be held hostage? Could Massachusetts, or any state, for that matter, require physicians, as a condition of obtaining or renewing their licenses, to spend one day each week in a leper colony? Or in a maximum security prison? Or in the state national guard? Or, indeed, satisfying any state-perceived "social need," like performing surgery on HIV-positive patients?

Sadly, the answer may be yes, based on the principles articulated in the Massachusetts Medical Society decision, which the Supreme Court of the United States refused to review. In a way, the decision in that case should not have been surprising. The groundwork had been laid shortly before in a case decided by the Massachusetts Supreme Judicial Court.

## D. Failure of the Challenge Foretold

In the 1984 case of Walden v. Board of Registration in Nursing, registered nurse Nancy L. Walden received an application for license renewal from the Massachusetts Board of Registration in Nursing. Among other things, the application required that she certify under penalties of perjury that, to the best of her knowledge and belief, she had filed all state tax returns and paid all state taxes required under law. Because nurse Walden refused to certify that she was not a tax evader, the Board declined to process her application for license renewal. She sued, lost at trial, and appealed to the Massachusetts Supreme Judicial Court.

Just as the MMS and AMA would argue a year later in the Massachusetts federal district court, and later in the circuit court, Walden had contended in the state court that professional licenses could be made dependent only on fitness, not on collateral purposes that the state thought were important to accomplish. Anticipating what the MMS and AMA would contend later, here, in part, is what Walden argued. "The Supreme Judicial Court has also long recognized 'the right to enjoy life, liberty and the pursuit of happiness is secured to everyone under the Constitution of Massachusetts' and that 'this includes the right to pursue any proper vocation to obtain a livelihood.'"

Walden argued further that such a blatantly coercive statute did not deserve judicial deference, and that the Massachusetts' high court had in the past struck down legislation not rationally related to a legitimate governmental end.

[T]he oath requirement is a blatantly coercive legislative enactment undeserving of judicial deference. Where legislation such as this impacts so harshly upon protected liberty and property interests, the Court is obligated to determine whether the enactment impermissibly infringes upon such interests. In such an instance, "it is precisely the function of the judiciary under substantive due process, when conventional ideals and government action significantly and seriously diverge, to reassert the primacy of the ideals." A. Bickel, The Least Dangerous Bunch, 23-38 (1965).

There should be no hesitation to similarly invalidate the Disputed Law, as there is no "real and substantial" relation between the tax oath and either the state's interest in tax collection nor in the good character of its licensed nurses. As has been argued previously in this Brief, any true tax outlaw would have absolutely no aversion to falsely attesting to the oath. Realistically, the declaration cannot be said to bear a reasonable relationship to the prevention of tax avoidance. See Coffee-Rich, Inc. ... [Legislative 'regulations must be reasonable in their nature, directed to the prevention of real evils and adapted to the accomplishment of their avowed purpose.'"] If the license condition had nothing to do with the government's legitimate interest in tax collection, according to Walden it had even less to do with nursing.

Although the Superior Court strained to link the Disputed Law to the state's interest "in employing citizens of good characer" ... [Footnote omitted] there is neither record evidence nor ready inference that licensees who have complied with tax laws have better or worse character than those who have not and/or that

the Legislature was the least bit concerned with that notion when it enacted REAP, an unabashed effort aimed purely at increased tax collection. ... Although the state may certainly regulate nursing, in ways already mentioned in this Brief, to condition the practice of nursing upon a certification of compliance with state tax laws makes no more sense than to condition the right to drive a car on the highways upon the filing of census information, or the right to vote on the payment of speeding tickets. Thus, the Disputed Law infringes impermissibly upon the Appellant's constitutionally protected liberty and property interests in pursuing her profession and maintaining her license. Walden's arguments were constitutionally solid, and the Massachusetts' license servitude condition that affected her was even more remote from fitness than would be mandatory Medicare assignment. Yet, in language that would anticipate the result in the Massachusetts Medical Society case the next year, the Massachusetts Supreme Judicial Court flatly rejected Walden's claim that the state-demanded tax probity certification had nothing whatever to do with her fitness to be a nurse. Although the court recognized that Walden was arguing "that because occupational licensing is involved, [the law] must have a rational basis related to her profession or her practice of it," and although it recognized that "[t]here is language in Schware ... which tends to support [Walden's] claim that the rational basis for regulatory legislation must relate to her competence to practice nursing," Massachusetts' highest court was unpersuaded. Even if the Schware decision meant what it seemed to say, according to the Supreme Judicial Court, "the fact that a licensee of the Commonwealth, at least a nurse, had knowingly failed to comply with the tax laws of the Commonwealth could be treated rationally as an anti-social act demonstrating unfitness to carry on a responsible profession in which adherence to other laws is required."

## Conclusion

The Massachusetts Medical Society and Walden cases teach a hard lession, and send a strong, unequivocal message to the physicians not only of Massachusetts, but throughout the nation: while fitness remains the core requirement for the granting and renewal of a professional license, as surely it must, now, expressly according to Walden and implicitly according to Massachusetts Medical Society, "anti-social acts" are to be synonymous with "unfitness." "Anti-social acts" like refusing to spend one day a week practicing in a leper colony? Or in a maximum security prison? Or refusing to join the state National Guard? Or doing anything else that the state might deem socially useful?" LIke refusing to perform surgery on HIV-positive patients.

The American Medical Association certainly does not think so, having in 1982 gone on record as opposing any conditions on a physician's license except fitness: "The Council believes that licensure laws should be related solely to physician competence and that licensing boards should be charged with responsibility for matters relating to competence. The boards should not be charged with responsibility for accomplishing other state objectives, including health care cost containment for the elderly.

Unfortunately, the "other state objectives" sought to be accomplished by legislatures are not going to end with health care cost containment for the elderly (many of whom, it should be noted, are more affluent than the physicians who treat them). For example, at about the same time that mandatory Medicare assignment as a condition for licensure came to Massachusetts, a bill was introduced in that legislature attaching the same conditions for Medicaid patients. Although it did not pass, the idea behind the bill was exactly the same as the idea upon which mandatory Medicare assignment rests, and idea now validated constitutionally by both the highest federal and state courts in Massachusetts: the physicians' license to practice medicine is held in servitude to state-perceived medical needs.

Given that those needs are growing larger every day, as the Bipartisan Commission report discussed above makes clear, it is only a matter of time until other states latch on to the idea that they can "solve" their perceived health care needs not by politically unpopular and often unacceptable method of raising taxes generally, but rather by increasing the servitude of America's physicians. Their licenses will then become a yoke by which they will be pulled toward state-dictated medical servitude. Eventually, more and more of America's

physicians will refuse to practice as mere handmaids of government. Actually, that is already happening.

My patients ask me why, after six years in the private practice of neurosurgery in the Boston-North Shore area, I am leaving to practice elsewhere. I tell them that the many assaults physicians in Massachusetts have to endure has left me with no other choice. n the past six years, the number of neurosurgeons practicing in Massachusetts has dropped from more than 120 to less than 80. Few physicians choose to move to Massachusetts to begin a practice, despite the fact that the Boston medical community has always held a position of world prominence. *** However, the overseers of medicine in Massachusetts tend to treat physicians as though they are antisocial, amoral incompetents who need to be controlled like circus animals. *** Fortunately, one of the things that is still permitted for Massachusetts physicians is the right to leave and practice elsewhere. I will miss my patients. So will they all. And, surely, will we miss them.

## Endnotes

1. Holzman, AIDS Fear Alters Surgeon's World, Insight Magazine, Oct. 15, 1990, at 52 (emphasis added).

2. The Commission was called the "Pepper Commission," after its then-Chairman, Florida Senator Claude Pepper.

3. Tolchin, Panel Says Broad Health Care Would Cost $86 Billion a Year, N.Y. Times, Mar. 3, 1990, at 1, col. 1. Obviously, the recipients of that care would include AIDS sufferers.

4. Id. at 9, col. 1.

5. Id. at 1, col. 1.

6. Id.

7. Rosenthal, Some Point to Massachusetts as Extreme of Regulation, N.Y. Times, Feb. 19, 1990, at A13, col. 1

8. "Balance billing" refers to the amount billed by a physician to a patient that constitutes the difference between the physician's actual charge and the reimbursement received from Medicare. 1989 W. Va. Acts, ch. 16, art. 29B, 16-29-D-4.

9. Id. 16-29-D-1

10. Morse, Why I Resigned from the Board, Mass. Med., Mar./Apr. 1986, at 13-14.

11. Id. at 14.

12. Id.

13. Id.

14. Id.

15. Forgotson, Roemer, & Newman, Licensure of Physicians, 1967 Wash, U.L.Q., 249.

16. W. Va. Code, ch. 93, 9 (1882).

17. Id. See Dent v. West Virginia, 192 U.S. 114, 117 (1889).

18. 129 U.S. 114 (1889).

19. Id. at 117-18.

20. Id. at 122.

21. Id. at 123.

22. Id. at 128.

23. Thus, state imposed requirements relating to education and even experience are clearly within the police power. Although requirements of "character and fitness" (see Schware v. Board of Law Examiners, 353 U.S. 232 (1959), arguably go too far when the criteria are skill and learning, the former requirements have been updated as rationally related to the latter. The excuses given for citizenship and residence requirements have been based on the notion that somehow United States citizens and state residents make better licensed professionals. Those requirements are now gone. See In re Griffiths, 413 U.S. 717 (1973) and Supreme Court of New Hampshire v. Piper, 470 U.S. 274 (1985). Even less defensible is Idaho's requirement, for example, that prior to a physician's licensure or the renewal of a license, malpractice insurance must be in place. Nevertheless, in passing on the constitutionality of Idaho Code section 39-4206(6) (1975), the Supreme Court of Idaho stressed that, similar to the protection afforded patients by the state requiring that the physician possess a certain level of skill and learning, the malpractice insurance requirement provided "protection to patients who may be injured as a result of medical malpractice ... " Jones v. State Bd. of Medicine, 97 Idaho 859, 555 P.2d, 399, 408 (1976).

24. 353 U.S. 232, 239 (1959).

25. Mass. Gen. L. ch. 112, 2 (1985) (emphasis added). The Association of Retired Persons Bulletin of September 1990

reported at page six that "[m]ore states are placing tighter limits on the amount doctors can charge their Medicare patients." According to AARP, Pennsylvania, Massachusetts, and Rhode Island have prohibited balance billing and a new law will "bar doctors in New York from billing patients more than 15 percent in excess of Medicare's approved rate. That amount will drop to about 10 percent by 1993." AARP also reported that "Vermont and Connecticut bar doctors from charging low-income beneficiaries more than Medicare's approved rate. Other patients may be charged up to the federal limit, which, as previously noted, will next year cap the amount that physicians may bill in excess of the approved rate at 25 percent."

26. A thorough, painstaking search and analysis of the statutes and rules governing medical licenses in each of the other 49 states has failed to reveal anything even remotely similar to the license servitude imposed on the physicians of Massachusetts.

27. 637 F. Supp. 684 (D. Mass. 1986).

28. "The reasonable charge is calculated by HHS on the basis of the physician's own 'customary charge' for that service as well as the 'prevailing charge' in the locality for similar services. 42 U.S.C. sec 1395u(b)(3). 42 C.F.R. 405.502(a)." Massachusetts Medical Soc'y; 637 F. Supp. at 686.

29. Massachusetts Medical Soc'y; 637 F. Supp. at 686. See supra note 8.

30. Plaintiff's Reply Memorandum of Law in Support of Request For Declaratory Relief, at 33, Massachusetts Medical Soc'y v. Dukakis, 637 F. Supp. 684 (D. Mass. 1986).

31. 291 U.S. 502 (1934).

32. North Dakota State Bd. of Pharmacy v. Snyder's Drugstores Inc., 414 U.S. 156 (1973); Ferguson v. Skrupa, 372 U.S. 726 (19630; Williamson v. Lee Optical Co., 348 U.S. 483 (1973); Minnesota Ass'n of Health Care Facilities, Inc., v. Minnesota Dep't of Pub. Welfare, 742 F.2d 442 (ith Cir. 1984); Whitney v. Heckler, 780 F.2d 963 (11th Cir.), cert. denied. 479 U.S. 813 (1986); Massachusetts Nursing Ass'n v. Dukakis, 726 F.2d 41 (1st Cir. 1984); American Medical Ass'n v. Heckler, 606 F. Supp. 1422 (S.D. Ind. 1985).

33. The MMS and the AMA argued that the four Massachusetts cases cited by the defendants confirmed that a condition on licensure must bear a relationship to "capacity or fitness." Walden v. Board of Registration in Nursing, 395 Mass. 263, 479 N.E. 2d 665 (1985), involved a certification that the applicant for licensure had paid his or her taxes. Raymond v. Board of Registration in Medicine, 387 Mass. 708, 433 N.E. 2d 391 (1982), concerned the illegal possession of unregistered weapons. Feldstein v. Board of Registration in Medicine, 387 Mass. 339, 439 N.E. 2d 824 (1982), dealt with Medicaid fraud. Levy v. Board of Registration in Medicine, 378 Mass. 519, 392 N.E. 2d 1036 (1979), involved grand larceny. In all these cases, the Supreme Judicial Court stressed that the conduct that triggered licensure sanctions demonstrated the licensee's lack of fitness or capacity to practice.

34. In support of this proposition, the MMS and the AMA cited Hampton v. Mow Sun Wong, 426 U.S. 88 (1976), Truax v. Raich, 239 U.S. 33 (1915), and Silver v. Garcia, 760 F.2d 33 (1st Cir. 1985). Also cited was Stalland v. Board of Bar Examiners, 530 F. Supp. 155 (D.S.D. 1982).

35. Massachusetts Medical Soc'y, 637 F. Supp. at 703 (emphasis added).

36. Id. at 706 (emphasis added).

37. Id.

38. Id at 706-07 (emphasis added) (citations omitted).

39. Massachusetts Medical Soc'y v. Dukakis, 815 F.2d 790 (1st Cir. 1987).

40. Massachusetts Medical Soc'y, 815 F.2d at 797 (emphasis added).

41. 395 Mass. 263, 479 N.E. 2d 665 (1985).

42. See Mass. Gen. L. ch. 62C, 49A (1984).

43. Brief for Plaintiff-Appellant, Supreme Judicial Court of Massachusetts, Walden v. Board of Registration in Nursing, 395 Mass. 263, 479 N.E. 2d 665 (1985).

44. Id.

45. Id.

46. Walden, 479 N.E. 2d at 671.

47. Id.

48. Id. at 672 (emphasis added).

49 Counsel on Medical Education, The Report on Medical Licensure, 259 J.A.M.A. 1994, 1999 (1988).

50. Kornel, Why M.D.'s Leave: One Physician's Tale, The Boston Herald, Sept. 12, 1990, at 39 (emphasis added).