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2005

## One and Done: How Ohio's One-Year, Nonrenewable Visiting Medical Faculty Certificate is Harming the State's Economic Recovery

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### Recommended Citation

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ONE AND DONE: HOW OHIO’S ONE-YEAR, NONRENEWABLE  
VISITING MEDICAL FACULTY CERTIFICATE IS HARMING  
THE STATE’S ECONOMIC RECOVERY

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#### I. INTRODUCTION

In 1992, the State of Ohio Medical Board (the board) recommended that the legislature create the Visiting Faculty Certificate, a license that allows certain non-fully-licensed doctors to practice in the state for one year.<sup>1</sup> A then board member hailed it as a "terrific idea [that would] solve a lot of problems, allowing Ohio to attract physicians" to the state.<sup>2</sup> Unfortunately, because it is nonrenewable and expires after one year, the Visiting Faculty Certificate has not lived up to its promise

<sup>1</sup>OHIO ADMIN. CODE 4731:6-32 (2005); OHIO REV. CODE ANN. § 4731.293 (LexisNexis 2005). The statute calls this license a "Visiting medical faculty certificate," whereas the regulation calls it a "Visiting faculty certificate." OHIO ADMIN. CODE 4731:6-32 (2005); OHIO REV. CODE ANN. § 4731.293 (LexisNexis 2005). The note will refer to this license as the "Visiting Faculty Certificate."

<sup>2</sup>The State Medical Board of Ohio, *Meeting Minutes*, October 10, 1990, 5235 at 5254 [hereinafter *Meeting Minutes*, October 1990] (quoting the meeting minutes) (on file with author). Board member Dr. Carla O'Day made this remark before the board unanimously recommended that the legislature enact the one-year, nonrenewable Visiting Faculty Certificate. *Id.*

and has actually harmed Ohio. Consider the following hypothetical about Dr. Marcus Bierman, whose departure from the state illustrates one way that the one-year, nonrenewable Visiting Faculty Certificate can negatively affect Ohio.<sup>3</sup>

Doctors at Case Western Reserve University (Case) recruited Dr. Bierman, an experienced and accomplished German radiologist, to come to Cleveland, Ohio, to conduct medical research.<sup>4</sup> This research involved the clinical care of patients, which requires a medical license. So, before coming to America, Dr. Bierman applied for and received Ohio's one-year, nonrenewable Visiting Faculty Certificate, the only medical license immediately available to him because he is a foreign-educated doctor.<sup>5</sup> After Dr. Bierman arrived in Cleveland, the National Institutes of Health granted him \$300,000 to conduct his research. Dr. Bierman allocated the grant to equipment and salaries for his research assistants and himself.

Dr. Bierman conducted his research for one year, until his Visiting Faculty Certificate expired. Unable to continue his research in Ohio without a medical license, Dr. Bierman left the state and moved to North Carolina, which allows foreign doctors to practice indefinitely under a license similar to the Visiting Faculty Certificate.<sup>6</sup> When Dr. Bierman moved to North Carolina, he took with him his National Institutes of Health grant, the job that he created, his expertise, and the equipment that he purchased. After moving to North Carolina, Dr. Bierman received other National Institutes of Health grants to perform other important medical research.

As this hypothetical illustrates, the one-year, nonrenewable Visiting Faculty Certificate harms Ohio. Not only does it drive highly-qualified doctors from the state, but it also discourages them from coming to Ohio. In recent years, Ohio has lost thousands of jobs as major corporations and government entities have left the state.<sup>7</sup> Meanwhile, Ohio has been trying to correct this trend by taking advantage of

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<sup>3</sup>Dr. Bierman is a fictional character. The author based this hypothetical on a discussion with Charles F. Lanzieri, M.D., F.A.C.R., Interim Department Chairman, Radiology, Professor, University Hospitals Professor, Case Western Reserve University. The author would like to thank Dr. Lanzieri for not only coming up with this hypothetical, but also suggesting the topic and providing insight where needed.

<sup>4</sup>As used throughout this note, "foreign doctors" means doctors educated outside of the United States and Canada. "Foreign doctors" are not necessarily non-American citizens and might include American citizens educated in foreign medical schools. Although this hypothetical focuses on a foreign doctor, the Visiting Faculty Certificate is available to doctors from other states and foreign countries, both of whom Ohio should be trying to attract and retain. OHIO ADMIN. CODE 4731:6-32 (2005); *see also* OHIO REV. CODE ANN. § 4731.293 (LexisNexis 2005).

<sup>5</sup>OHIO ADMIN. CODE 4731:6-32 (2005); OHIO REV. CODE ANN. § 4731.293 (LexisNexis 2005).

<sup>6</sup>21 N.C. ADMIN. CODE 32B.0801 (2005). North Carolina's version of the Visiting Faculty Certificate lasts indefinitely in the sense that the statute does not impose a time restriction on the doctor; instead, the doctor's license expires when "its holder ceases to be a resident in the training program or obtains any other license to practice medicine issued by the board." *Id.*

<sup>7</sup>Alex Machaskee, Op-Ed., *We Need a Plan to Push Cleveland Forward*, THE PLAIN DEALER (Cleveland, Ohio), May 29, 2005, at H1.

its universities, world-class hospitals, and research centers<sup>8</sup> and moving towards a “knowledge-based” economy.<sup>9</sup> But, as medical-research doctors depart and are discouraged from coming to the state — with their expertise, research, and technology — Ohio’s effort to establish itself as a bio-tech hub becomes more difficult.<sup>10</sup> An amended, *renewable* Visiting Faculty Certificate can help solve Ohio’s problems by attracting doctors to the state and making it easier for them to stay in Ohio. Besides making the Visiting Faculty Certificate renewable, Ohio can make patients safer by adding requirements to receive and maintain that license.

This note is divided into nine parts. Part II of this note explains the history of medical licensing in America and Ohio and describes Ohio’s Visiting Faculty Certificate. Part III discredits three of four possible arguments for keeping the Visiting Faculty Certificate nonrenewable, and part IV quantifies and discusses the Visiting Faculty Certificate’s effect on Ohio. Part V describes other states’ visiting-faculty licenses and prescribes how Ohio should make the Visiting Faculty Certificate renewable. Part VI suggests additional Visiting Faculty Certificate requirements to make patients safer, and part VII points out ambiguities in the Visiting Faculty Certificate. Part VIII cites Ohio precedents for a renewable Visiting Faculty Certificate. Part IX concludes this note, and part X updates this note with developments that occurred during the editing process.

## II. MEDICAL-LICENSING HISTORY AND OHIO’S MEDICAL-LICENSING LAWS

Throughout America’s history, licensure of the medical profession has been controversial. Medical-licensing proponents argue that licensure reduces or eliminates phony doctors, protects the public from the harm and the cost of “dubious and ineffective therapies,” and improves education and training.<sup>11</sup> Conversely,

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<sup>8</sup>*E.g.*, Case Western Reserve University, the Cleveland Clinic Foundation, University Hospitals of Cleveland, the NASA Glenn Research Center, Cleveland State and Kent State Universities, and the University of Akron. Edward M. Hundert, Op-Ed., *A Billion-Dollar-A-Year Target for NE Ohio Research Centers*, THE PLAIN DEALER (Cleveland, Ohio), Nov. 28, 2005, at B7.

<sup>9</sup>Op-Ed., *Case for the Future Vision of a Modern Medical Mecca on University Circle Holds Tremendous Promise for all of Greater Cleveland*, THE PLAIN DEALER (Cleveland, Ohio), Feb. 24, 2005, at B8.

<sup>10</sup>*Id.*

<sup>11</sup>Gregory Dolin, *Licensing Health Care Professionals: Has the United States Outlived the Need for Medical Licensure?*, 2 GEO. J.L. & PUB. POL’Y 315, 321 (2004); *see also* STANLEY J. GROSS, *OF FOXES AND HEN HOUSES* (1984). Those in favor of licensure also might argue that it has public-welfare and professional-welfare purposes. GROSS, *supra*, at 16. Three reasons support the public-welfare rationale. *Id.* at 17. First, consumers cannot distinguish between the incompetent and competent doctor and, even if they had the necessary information to make a correct choice, that information is “difficult, costly, and time-consuming to obtain and when available often requires sophistication to interpret.” *Id.* Second, if patients were allowed to choose non-licensed doctors and they chose poorly, that choice would not only affect themselves, but also society as a whole. *Id.* at 19. Third, even if patients could choose for themselves, “they still would not be the best judges of what is in their own welfare; society knows better.” *Id.* at 18. Two reasons support the professional-welfare rationale. *Id.* at 20. “First, the creation of a competitive advantage through a state-ordained monopoly . . . leads to a heightened income and job security for those meeting the special qualifications.” *Id.*

medical-licensing opponents argue that limiting medical licenses to a select group creates a monopoly which raises prices and stifles innovation.<sup>12</sup> Regardless of the reasons for and against medical licensing, any vocation that “evolve[s] specialized skills . . . seek[s] to limit membership to those who attained such skills.”<sup>13</sup> The rest of this section summarizes America’s and Ohio’s medical-licensing histories and describes Ohio’s Visiting Faculty Certificate.

*A. America’s Early Medical-Licensing History: Licensure, Deregulation, Licensure*

Since 1649, when the colony of Massachusetts adopted a law that regulated doctors, people in America have tried to protect both the public and the medical profession through licensing.<sup>14</sup> Most colonial medical laws regulated fees, rather than the quality of services.<sup>15</sup> Although England’s Royal College of Physicians had licensing power over the English medical profession by 1745, Parliament did not allow it to exercise that power over England’s American colonies.<sup>16</sup> England’s decentralized approach to licensing differed from that of Spain, which extended its medical-licensing laws to its American colonies.<sup>17</sup> By using that approach, England influenced how the United States would leave medical licensing to the states, rather than have a centralized, national licensing system.<sup>18</sup>

In America, “virtually no oversight over medical practice had been exercised before 1780.”<sup>19</sup> Because few colonial medical schools existed, it was hard to “enforce or even to define licensing standards.”<sup>20</sup> By 1815, most of the original states — and by 1830, most other states — had established medical societies, which advocated for exams and licensing.<sup>21</sup> State legislatures responded by creating state examining boards or by granting medical societies the power to test and license.<sup>22</sup> Massachusetts’ medical society originally had the sole power to grant licenses.<sup>23</sup>

Second, “occupations in pursuit of dignity and prestige have sought licensing to enhance their public image.” *Id.*

<sup>12</sup>Dolin, *supra* note 11, at 322-23; *see also* COUNCIL OF STATE GOVERNMENTS, OCCUPATIONAL LICENSING REGULATION IN THE STATES, (1952). Those against licensure also might argue that “unduly restrictive experience and educational requirements” limit the number of entrants into the profession and, thus, create an “artificial scarcity of trained men.” COUNCIL OF STATE GOVERNMENTS, *supra*, at 3.

<sup>13</sup>RICHARD HARRISON SHRYOCK, MEDICAL LICENSING IN AMERICA, 1650-1965 viii (1967).

<sup>14</sup>*Id.* at vii.

<sup>15</sup>*Id.* at viii.

<sup>16</sup>*Id.* at vii, 7-8.

<sup>17</sup>*Id.* at 8.

<sup>18</sup>*Id.*

<sup>19</sup>*Id.* at 24.

<sup>20</sup>*Id.* at 108.

<sup>21</sup>*Id.* at 23. *But see* GROSS, *supra* note 11, at 53 (stating that “[b]y 1800 thirteen of the sixteen states had given the authority to examine and license to the state medical societies”).

<sup>22</sup>SHRYOCK, *supra* note 13, at 23.

<sup>23</sup>*Id.* at 25-26.

After 1803, however, a candidate could receive a license by either having a Harvard diploma or passing the medical society's exam.<sup>24</sup> Even with many other states following this "dual system," medical schools licensed most nineteenth-century doctors.<sup>25</sup>

From 1820 until 1875, medical schools controlled licensing in most states. States revoked medical boards' licensing power for at least three possible reasons.<sup>26</sup> First, "irregular" doctors (e.g., homeopathic, eclectic, and botanic) argued that licensure created a monopoly for "regular" doctors and limited the number of doctors, thus increasing fees.<sup>27</sup> Second, state legislatures thought that one kind of medical practice was as effective as another.<sup>28</sup> Third, the medical profession "suffered from the individualism and anti-intellectualism associated with Jacksonian democracy" — i.e., people generally distrusted doctors as a learned group and believed that people could evaluate competence for themselves.<sup>29</sup> Differing opinions exist on the effects of deregulation. One view is that because students paid professors directly, professors lowered standards so that they could enroll as many students as possible; thus, licensing requirements "deteriorated" when medical schools licensed doctors.<sup>30</sup> Another view is that without the control on the supply of doctors that licensing provided, the number of doctors increased, and few doctors made a good living.<sup>31</sup> Under yet another view, deregulation raised standards and increased the number of doctors and medical schools, making health care more affordable, accessible, and safer.<sup>32</sup>

Regardless, by the Civil War, no state had an effective state-controlled licensing system.<sup>33</sup> Towards the end of the nineteenth century, however, states started to re-establish medical boards.<sup>34</sup> Two possible reasons for this shift towards state-controlled licensing exist. One possible reason is that newly-formed medical associations, emboldened by a reform movement based on reason and science, lobbied the states to limit the competition within and outside of the medical

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<sup>24</sup>*Id.*

<sup>25</sup>*Id.* at 25-26, ix.

<sup>26</sup>*Id.* at 28-29, 109. Other possible reasons for the deregulation of the medical profession include that (1) licensed doctors made things so complicated that patients could not understand the doctors' directions on how to take care of themselves, (2) licensure stifled breakthroughs and prevented talented "irregular" doctors from practicing, and (3) licensure maintained a class system by preventing people from the lower classes from entering the profession. GROSS, *supra* note 11, at 54.

<sup>27</sup>SHRYOCK, *supra* note 13, at 28-29.

<sup>28</sup>*Id.*

<sup>29</sup>*Id.* at 109

<sup>30</sup>SHRYOCK, *supra* note 13, at 27.

<sup>31</sup>CARL F. AMERINGER, STATE MEDICAL BOARDS AND THE POLITICS OF PUBLIC PROTECTION 15 (1999).

<sup>32</sup>GROSS, *supra* note 11, at 55.

<sup>33</sup>*Id.* at 54.

<sup>34</sup>*Id.* at 57.

profession.<sup>35</sup> States obliged by creating medical boards, which used licensing to limit the number of doctors and to prohibit non-doctors from practicing.<sup>36</sup> The other possible reason for re-establishing medical boards is that because “poor” medical schools had “discredited” degrees, reformers proposed that medical societies regain sole licensing authority.<sup>37</sup> As the profession advocated for placing licensing power with states, medical-board opponents argued that America needed “second-grade” doctors to care for the poor, that “innate talents” could make up for a lack of education, and that reformers wanted to create a monopoly.<sup>38</sup>

By 1900, most states had enacted medical-licensing laws.<sup>39</sup> Doctors who practiced before the states passed those laws and did not meet the new requirements challenged those laws as unconstitutional takings of property without due process and just compensation.<sup>40</sup> *Dent v. West Virginia* involved a doctor who had practiced before West Virginia passed its medical-license law and did not meet the new law’s requirements. The doctor argued that practicing medicine was a property right of which the state deprived him without due process and just compensation.<sup>41</sup> The United States Supreme Court rejected the doctor’s argument, holding that the states’ police power allows them to set medical-license requirements related to the medical profession.<sup>42</sup> With that decision, medical associations succeeded in “tying the interest of the [s]tate with the interests of the medical profession.”<sup>43</sup>

According to a 1910 study, the medical-education system in the United States was “for-profit, and standardless.”<sup>44</sup> After reviewing that study, thirty-nine states no longer relied on medical-school diplomas for licensure, the number of medical schools was reduced, and the remaining medical schools standardized their

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<sup>35</sup>*Id.* at 56-57. (stating, also, that the “motivating force behind licensing [included] the vulnerability felt by professionals . . . less able in [those] tempestuous times to use the class system to maintain a privileged status for the university educated”); AMERINGER, *supra* note 31, at 7.

<sup>36</sup>GROSS, *supra* note 11, at 56-7; AMERINGER, *supra* note 31, at 7.

<sup>37</sup>SHRYOCK, *supra* note 13, at 45.

<sup>38</sup>*Id.* at 43, 59.

<sup>39</sup>AMERINGER, *supra* note 31, at 16.

<sup>40</sup>Edward P. Richards, *The Police Power and the Regulation of Medical Practice: A Historical Review and Guide for Medical Licensing Board Regulation of Physicians in ERISA-Qualified Managed Care Organizations*, 8 ANNALS HEALTH L. 201, 212-14 (1999).

<sup>41</sup>*Dent v. West Virginia*, 129 U.S. 114 (1889); *see also Hawker v. New York*, 170 U.S. 189 (1898). In *Hawker v. New York*, a convicted-felon doctor continued to practice medicine after the state changed its medical-license law to prohibit felons from practicing medicine. *Hawker*, 170 U.S. at 189. The doctor argued that the changes to medical-license law that prohibited him from practice were ex-post facto violations of his constitutional rights. *Id.* at 190. Upholding New York’s amendment to its medical-license law, the United States Supreme Court held that “legislation which simply defines the qualifications of one who attempts to practise (sic) medicine is a proper exercise of the state’s police power.” *Id.* at 193.

<sup>42</sup>*Dent*, 129 U.S. at 114.

<sup>43</sup>GROSS, *supra* note 11, at 56.

<sup>44</sup>Dolin, *supra* note 11, at 318.



curricula.<sup>45</sup> States that continued to rely on graduation from a medical school for licensure required applicants to receive a degree from a school accredited by the Council on Medical Education, an organization that sought to reduce the number of medical schools.<sup>46</sup> Exam reforms followed those reforms in medical education and continued throughout the twentieth century. In 1915, the National Board of Medical Examiners was created to administer national exams;<sup>47</sup> during the rest of the twentieth century, exams became more standardized.<sup>48</sup> Finally, in 1994, the United States Medical Licensing Exam, which all states now require for licensure, replaced the four existing exams.<sup>49</sup>

### B. *The Formation of the Modern Medical Board*

Like medical education and exams, medical boards were reformed throughout the twentieth century. Before the 1980s, medical boards rarely disciplined doctors and, if they did, it was almost never for incompetence.<sup>50</sup> Early medical boards excluded incompetence as a ground for revoking a doctor's license for many reasons, including the following: (1) doing so was consistent with English precedent; (2) practicing medicine needed only "good judgment," because medicine was an inexact science; (3) disciplining licensed doctors was not the medical boards' role; (4) lacking resources — i.e., money and people — medical boards could not discipline doctors; and (5) disciplining doctors would give the profession negative publicity.<sup>51</sup> Although charged with protecting the public, for most of the twentieth century, medical boards acted like "gatekeepers guarding entry into the profession, rather than internal police over substandard care."<sup>52</sup>

After states established medical boards, medical boards worked to extend the "boundaries of medical practice as far as possible."<sup>53</sup> Medical boards accomplished this goal by using licensure to restrict the doctor supply and to prosecute non-doctors for practicing without a license.<sup>54</sup> Chiropractors were one group of practitioners that medical boards targeted, using three unsuccessful techniques: (1) attacking them as uneducated; (2) prosecuting them for practicing without medical licenses; and (3) requiring them to take an exam that actually ended up producing a "high failure rate"

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<sup>45</sup>*Id.* In 1904 the United States had 162 medical schools, more than all other countries combined. AMERINGER, *supra* note 31, at 20. By the end of 1918, only eighty-five schools survived. *Id.*

<sup>46</sup>AMERINGER, *supra* note 31, at 20.

<sup>47</sup>Dolin, *supra* note 11, at 319.

<sup>48</sup>*Id.*

<sup>49</sup>*Id.* at 320.

<sup>50</sup>AMERINGER, *supra* note 31, at 2.

<sup>51</sup>*Id.* at 18.

<sup>52</sup>*Id.* at 1.

<sup>53</sup>*Id.* at 25.

<sup>54</sup>AMERINGER, *supra* note 31, at 10-11. Although licensing laws initially restricted the use of the title "doctor," medical societies had legislatures change the laws to allow only licensed individuals to practice medicine. GROSS, *supra* note 11, at 58.

among doctors and deterred “few chiropractors, many of whom [could] pass the examination, anyway.”<sup>55</sup> Chiropractors and other “irregular” doctors, however, were not the medical boards’ only target. Medical boards also sought to limit the profession to white males and to those doctors who would not compete with existing doctors.<sup>56</sup> Accordingly, medical boards used oral interviews to restrict competition and to exclude candidates on the basis of sex, race, and religion.<sup>57</sup> The medical profession’s reliance on medical boards to prevent chiropractors and others from practicing diminished as health care began to take place in hospitals, where medical staffs denied hospital privileges to whomever they desired.<sup>58</sup>

From the end of World War II to 1965, doctors practiced in the profession’s “Golden Age,” a period when the medical profession was at a “peak of prestige, prosperity, and political and cultural influence — perhaps as autonomous as a profession could be.”<sup>59</sup> Although doctors now dominated health care, criticism started to mount against the profession for excessive fees, indifference to patients, and incompetence.<sup>60</sup> The medical profession was even receiving criticism from within: the American Medical Association reported that “disciplinary action by both medical societies and boards of medical examiners [was] inadequate” and called for greater attention to “examining competence and observance of law and ethics after licensure.”<sup>61</sup> With chiropractors and other “irregular” doctors no longer a threat, doctors had no one else to blame for the criticism.<sup>62</sup> Because medical boards disciplined few doctors through the 1960s, they had no evidence that they were policing the profession.<sup>63</sup> The medical profession responded to the criticism in two ways. First, medical societies formed grievance committees to resolve disputes between doctors and patients.<sup>64</sup> Second, medical societies and hospitals used their own “informal” procedures for punishing incompetent doctors.<sup>65</sup> By ostracizing

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<sup>55</sup>AMERINGER, *supra* note 31, at 26-27. The medical profession’s attack on chiropractors was actually more systematic and tenacious than described. First, the medical profession attacked chiropractors as being uneducated. *Id.* After that approach failed and chiropractors became more popular with the lower and middle classes, medical boards began to prosecute them for practicing without a medical license. *Id.* Then, after that approach “produced a sympathetic backlash” in some states, including Ohio, medical societies lobbied legislatures to pass laws requiring applicants to take an exam to receive a medical license. *Id.*

<sup>56</sup>*Id.* at 29.

<sup>57</sup>*Id.*

<sup>58</sup>*Id.* at 27-28. For example, Cleveland’s now-razed Mt. Sinai hospital, opened in 1916, was founded because, among other reasons, “it was difficult for Jewish physicians to obtain full privileges at most hospitals.” Kaye Spector, *Snapshot of 1915 Found in Mt. Sinai Time Capsule*, THE PLAIN DEALER (Cleveland, Ohio), March 4, 2006, at B3.

<sup>59</sup>AMERINGER, *supra* note 31, at 28.

<sup>60</sup>*Id.*

<sup>61</sup>*Id.* at 2.

<sup>62</sup>*Id.* at 28.

<sup>63</sup>*Id.*

<sup>64</sup>*Id.* at 11.

<sup>65</sup>*Id.* at 15.

doctors or by revoking doctors' hospital privileges, hospitals and medical societies were able to punish doctors for misbehaving.<sup>66</sup>

Those two approaches kept disputes among doctors and patients private and within the control of doctors, "so as not to tarnish the idealized image of the medical practitioner as a person worthy of the public's confidence and trust."<sup>67</sup> Grievance committees, however, did little to protect the public as they did not expose the problem of incompetent doctors and did not inform the public of the particular doctor involved in the grievance.<sup>68</sup> Although grievance committees were ineffective, discipline remained a local matter, not one for state medical boards.<sup>69</sup> Medical societies controlled medical boards by keeping them dependent on medical societies for expertise and resources.<sup>70</sup> Many medical societies also selected board members, housed board operations, and managed board staffs.<sup>71</sup> Even with the profession's leaders trying to get medical boards the money, people, and legal authority that they needed to discipline doctors, medical societies would not promote their efforts.<sup>72</sup> By not helping medical boards gain the resources that they needed, medical societies kept medical boards suited for one purpose: controlling competition through licensure.<sup>73</sup>

Although medical boards were dependent on medical societies, they could not withstand the pressure to reform from the public, the government, and corporations.<sup>74</sup> The failure of the medical boards to discipline incompetent doctors rallied public opinion against the profession.<sup>75</sup> The media reported instances where medical boards had not disciplined doctors for misdiagnosing illnesses, performing unnecessary surgeries, and botching operations.<sup>76</sup> According to one study released at the time, in the 1960s, "boards disciplined about 0.06 percent of the total number of licensed doctors in any given year. Almost half of all disciplinary actions concerned violations of narcotic laws, and most of the remaining cases consisted of actions for unethical conduct or mental illness."<sup>77</sup> Other studies showed that the education and training required to obtain a license were not enough to ensure that doctors would

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<sup>66</sup>*Id.* at 15, 37.

<sup>67</sup>*Id.*

<sup>68</sup>*Id.* at 37.

<sup>69</sup>*Id.* at 22. According to the American Medical Association, "almost without exception, discipline is a local matter, and since county societies handle discipline, the state[] [medical boards] have little or no knowledge of what is being done." *Id.*

<sup>70</sup>*Id.* at 38.

<sup>71</sup>*Id.* at 37.

<sup>72</sup>*Id.*

<sup>73</sup>*Id.*

<sup>74</sup>*Id.* at 29.

<sup>75</sup>*Id.*

<sup>76</sup>*Id.*

<sup>77</sup>*Id.* at 35.

perform competently throughout their careers.<sup>78</sup> Fueled by these reports and studies, organized groups of patients demanded that medical boards resolve complaints against incompetent doctors.<sup>79</sup>

During the 1970s and 1980s, increasing health care costs strained government budgets and decreased employers' profits.<sup>80</sup> Responding to evidence that medical-licensure laws created doctor shortages, which increased health care costs, the federal government sought to control soaring Medicare and Medicaid costs by introducing market competition into local medical communities.<sup>81</sup> In *Goldfarb v. Virginia State Bar*, the United States Supreme Court rejected the "learned professions" antitrust exemption and held that local legal practice affected interstate commerce and, thus, was subject to federal antitrust laws.<sup>82</sup> This decision allowed doctors denied hospital privileges to sue in federal court for treble damages and attorney's fees, alleging violations of federal antitrust laws.<sup>83</sup> As the Supreme Court made local medical communities susceptible to antitrust laws, state courts relaxed the requirements for patients to recover under medical malpractice.<sup>84</sup> More medical-malpractice litigation led to a "so-called crisis in the availability and affordability of malpractice insurance."<sup>85</sup> Some attributed the medical-malpractice claims to the medical profession's inability to eliminate incompetent doctors.<sup>86</sup> Although many states eventually agreed to make it harder for patients to recover for malpractice, they required boards to more closely scrutinize doctors for incompetence.<sup>87</sup>

Besides requiring medical boards to monitor doctors, states increased their participation in doctor oversight by enacting other reforms. To start, states required medical boards to include non-doctors to represent patients' interests and revoked some authority of the medical societies to select doctor board members.<sup>88</sup> Then, states made medical boards responsible for investigating more kinds of complaints, including malpractice.<sup>89</sup> States also passed a number of laws that gave the state oversight over medical boards and weakened the boards' relationships with medical societies: (1) sunset laws that required medical boards to lobby their legislatures to continue to exist after a certain number of years; (2) laws that allowed states and the

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<sup>78</sup>*Id.* at 36.

<sup>79</sup>*Id.* at 123.

<sup>80</sup>*Id.* at 122.

<sup>81</sup>*Id.* at 46.

<sup>82</sup>*Goldfarb v. Virginia State Bar*, 421 U.S. 773, 792-93 (1975) (holding, also, that the "State Bar[s] status as] a state agency . . . does not create an anti-trust shield that allows it to foster anticompetitive practices for the benefit of its members").

<sup>83</sup>AMERINGER, *supra* note 31, at 48.

<sup>84</sup>*Id.* at 48, 58.

<sup>85</sup>*Id.*

<sup>86</sup>*Id.* at 3.

<sup>87</sup>*Id.* at 48, 58.

<sup>88</sup>*Id.*

<sup>89</sup>*Id.*

public to access board records and meetings; and (3) laws that placed board operations within an executive department of the state.<sup>90</sup> Also, court-mandated changes in the legal process made medical board proceedings more formal.<sup>91</sup> Following these reforms, starting in the 1980s, patients began to rely on medical boards to discipline — and protect them from — incompetent doctors.<sup>92</sup>

### C. Ohio's Medical-Licensing History

Although no support for it exists in Ohio law, a source contends that Ohio placed licensing power with its state medical society “from the start.”<sup>93</sup> Regardless of whether that is true, Ohio passed a law in 1868 that allowed residents to practice medicine if they had practiced continuously for ten years, held a license from the medical society of another state or country, or graduated from a medical school.<sup>94</sup> In 1896, Ohio passed a law that created a “[s]tate board of medical registration and examination.”<sup>95</sup> This law also allowed applicants to practice medicine if they graduated from a medical school, practiced medicine when the legislature passed the law, or passed a board-approved exam.<sup>96</sup>

An Ohio court upheld the state's right to regulate and set qualifications for doctors.<sup>97</sup> In *Midwestern College of Massotherapy v. Ohio Medical Board*, the board issued a license to the college to teach massage therapy.<sup>98</sup> A few years later, the board issued new regulations that the college did not meet and denied it a certificate of good standing.<sup>99</sup> The college argued that because the legislature omitted standards in the statute that authorizes the board to issue rules governing the practice of medicine,<sup>100</sup> it unlawfully delegated legislative authority.<sup>101</sup> Upholding the statute,

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<sup>90</sup>*Id.*

<sup>91</sup>*Id.* at 58. “Although states’ administrative procedures acts and court rulings did not force boards to adhere to strict judicial requirements, the procedures that boards now had to follow were considerably more burdensome than they had been only a few years earlier.” *Id.*

<sup>92</sup>*Id.* at 55. With the coming of Health Maintenance Organizations (HMOs) in the 1980s and 1990s, patients would also rely on medical boards to protect them from the “excesses of managed care” and its motive to increase profits by limiting services to patients. *Id.* at 127-29.

<sup>93</sup>SHRYOCK, *supra* note 13, at 24.

<sup>94</sup>1868 LAWS OF OHIO 146.

<sup>95</sup>1896 LAWS OF OHIO 44 (codified, as amended, in REV. STAT. § 4403 (1908), later recodified, as amended, in OHIO REV. CODE ANN. § 4731.01 (LexisNexis 2005)).

<sup>96</sup>*Id.*

<sup>97</sup>*Midwestern Coll. of Massotherapy v. Ohio Med. Bd.*, 656 N.E.2d 963, 968 (Ohio Ct. App. 1995).

<sup>98</sup>*Id.*

<sup>99</sup>*Id.*

<sup>100</sup>OHIO REV. CODE ANN. § 4731.15(A)(1) (LexisNexis 2005).

<sup>101</sup>*Midwestern Coll.*, 656 N.E.2d 963, 967.

the court validated the board's right to set qualifications because it was a valid exercise of the state's police power to regulate public health and welfare.<sup>102</sup>

*D. Ohio's Current Medical-Licensing Laws*

By Ohio statute and regulations, applicants now may practice medicine if they satisfy the requirements of a board-issued<sup>103</sup> license.<sup>104</sup> The board issues several licenses, including<sup>105</sup> (1) Licenses by Examination,<sup>106</sup> (2) Licenses by Endorsement of Licenses Granted by Other States,<sup>107</sup> (3) Visiting Faculty Certificates,<sup>108</sup> (4) Special Activity Certificates,<sup>109</sup> (5) National Board Diplomates and Medical Council of Canada Licentiates Licenses,<sup>110</sup> and (6) Limited Certificates.<sup>111</sup> Five of those licenses require an applicant to pass an exam: (1) Licenses by Examination, (2) Licenses by Endorsement of Licenses Granted by Other States, (3) Special Activity Certificates, (4) National Board Diplomates and Medical Council of Canada Licentiates Licenses, and (5) Limited Certificates.<sup>112</sup> Although the board may issue licenses to National Board diplomates and Medical Council of Canada licentiates without requiring them to take an exam, one must pass exams to become a diplomate

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<sup>102</sup>*Id.* at 968.

<sup>103</sup>OHIO REV. CODE ANN. § 4731.05 (LexisNexis 2005) (authorizing the board to adopt regulations "to carry out the purposes of this chapter").

<sup>104</sup>A license is the "legal authorization issued by the board to practice medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery." OHIO ADMIN. CODE 4731:10-01 (2005).

<sup>105</sup>The board may also issue Volunteer's and Training Certificates. OHIO ADMIN. CODE 4731:6-14 (2005); OHIO ADMIN. CODE 4731:6-30 (2005). Because these licenses do not allow their holders to, respectively, be paid for their services and practice outside of their residency, internship, or fellowship program, they will not be discussed in this note. OHIO ADMIN. CODE 4731:6-14 (2005); OHIO ADMIN. CODE 4731:6-30 (2005).

<sup>106</sup>OHIO ADMIN. CODE 4731:6-14 (2005) (License by Examination).

<sup>107</sup>OHIO ADMIN. CODE 4731:6-16 (2005) (License by Endorsement of Licenses Granted by Other States); OHIO REV. CODE ANN. § 4731.29 (LexisNexis 2005).

<sup>108</sup>OHIO ADMIN. CODE 4731:6-32 (2005) (Visiting Faculty Certificate); OHIO REV. CODE ANN. § 4731.293 (LexisNexis 2005).

<sup>109</sup>OHIO ADMIN. CODE 4731:6-33 (2005) (Special Activity Certificate).

<sup>110</sup>OHIO ADMIN. CODE 4731:6-15 (2005) (National Board Diplomates and Medical Council of Canada Licentiates Licences); OHIO REV. CODE ANN. § 4731.29 (LexisNexis 2005).

<sup>111</sup>OHIO ADMIN. CODE 4731:6-31 (2005) (Limited Certificates); OHIO REV. CODE ANN. § 4731.292 (LexisNexis 2005).

<sup>112</sup>OHIO ADMIN. CODE 4731:6-14-33 (2005); OHIO REV. CODE ANN. § 4731.29 (LexisNexis 2005); OHIO REV. CODE ANN. § 4731.292 (LexisNexis 2005).

or licentiate.<sup>113</sup> Therefore, the only license that does not require applicants to pass an additional exam is the Visiting Faculty Certificate.<sup>114</sup>

Besides passing an exam, applicants also must satisfy educational requirements for five licenses.<sup>115</sup> Limited Certificates require applicants to graduate from Liaison Committee on Medical Education- or American Osteopathic Association-accredited medical schools.<sup>116</sup> Because these organizations accredit only American and Canadian medical schools, this license is not available to foreign doctors.<sup>117</sup> Applicants may satisfy four licenses' educational requirement by graduating from World Health Organization-acknowledged medical schools outside of the United States and Canada or by receiving a foreign medical certificate.<sup>118</sup> (1) Licenses by Examination, (2) Licenses by Endorsement of Licenses Granted by Other States, (3) Special Activity Certificates, and (4) National Board Diplomates and Medical Council of Canada Licentiate Licenses.<sup>119</sup> Applicants who satisfy the educational requirement by graduating from a foreign medical school also must pass a board-recognized screening exam and complete one year of clinical training at an American hospital.<sup>120</sup> Similarly, applicants who satisfy the educational requirement by earning the foreign medical certificate also must complete at least nine months of an American or Canadian residency, internship, or fellowship.<sup>121</sup> Therefore, the only

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<sup>113</sup>National Board of Medical Examiners, <http://nbme.org/program/nbmecert.asp> (last visited Feb. 10, 2006); Medical Council of Canada, <http://www.mcc.ca/english/examinations/index.html> (last visited Feb. 10, 2006).

<sup>114</sup>OHIO ADMIN. CODE 4731:6-32 (2005); OHIO REV. CODE ANN. § 4731.293 (LexisNexis 2005).

<sup>115</sup>OHIO ADMIN. CODE 4731:6-14-33 (2005); OHIO REV. CODE ANN. § 4731.29 (LexisNexis 2005); OHIO REV. CODE ANN. § 4731.292 (LexisNexis 2005); *see also* OHIO REV. CODE ANN. § 4731.09 (LexisNexis 2005) (preliminary education); OHIO REV. CODE ANN. § 4731.091 (LexisNexis 2005) (medical education and graduate medical education); OHIO REV. CODE ANN. § 4731.14 (LexisNexis 2005) (other educational requirements).

<sup>116</sup>OHIO ADMIN. CODE 4731:6-31 (2005); OHIO REV. CODE ANN. § 4731.292 (LexisNexis 2005).

<sup>117</sup>Liaison Committee on Medical Education, <http://www.lcme.org/directry.htm> (last visited Feb. 10, 2006); American Osteopathic Association, [http://www.osteopathic.org/index.cfm?PageID=sir\\_college](http://www.osteopathic.org/index.cfm?PageID=sir_college) (last visited Feb. 10, 2006).

<sup>118</sup>The Educational Commission for Foreign Medical Graduates issues what the author calls throughout this note the "foreign medical certificate." Educational Commission for Foreign Medical Graduates, <http://www.ecfmg.org/cert/index.html> (last visited Feb. 10, 2006).

<sup>119</sup>OHIO ADMIN. CODE 4731:6-14-33 (2005); OHIO REV. CODE ANN. § 4731.29 (LexisNexis 2005); OHIO REV. CODE ANN. § 4731.091 (LexisNexis 2005); OHIO REV. CODE ANN. § 4731.14 (LexisNexis 2005).

<sup>120</sup>OHIO ADMIN. CODE 4731:6-14-33 (2005); OHIO REV. CODE ANN. § 4731.29 (LexisNexis 2005); OHIO REV. CODE ANN. § 4731.292 (LexisNexis 2005); *see also* OHIO REV. CODE ANN. § 4731.092 (LexisNexis 2005).

<sup>121</sup>OHIO ADMIN. CODE 4731:6-14-33 (2005); OHIO REV. CODE ANN. § 4731.29 (LexisNexis 2005); OHIO REV. CODE ANN. § 4731.292 (LexisNexis 2005); *see also* OHIO REV. CODE ANN. § 4731.091 (LexisNexis 2005).

license that does not require a foreign doctor to complete additional education or training is the Visiting Faculty Certificate.<sup>122</sup>

Because the Visiting Faculty Certificate does not require additional exams, training, or education, it is the only license available to foreign doctors who want to practice and conduct research immediately after arriving in Ohio.<sup>123</sup>

#### *E. Ohio's Visiting Faculty Certificate*

The board may issue a Visiting Faculty Certificate to an applicant who holds a “current, unrestricted license” to practice medicine in another state or country and has been appointed to an Ohio medical school’s faculty.<sup>124</sup> A “current, unrestricted license” is a license granted by the applicant’s state or foreign government that allows the applicant to practice all branches of medicine without governmental restriction.<sup>125</sup> Visiting-faculty doctors<sup>126</sup> may practice in areas incidental to their teaching duties at the medical school that appointed them or at that medical school’s teaching hospital.<sup>127</sup> The nonrenewable Visiting Faculty Certificate expires when the visiting-faculty doctor’s faculty appointment ends or after one year, whichever is shorter.<sup>128</sup>

Little information exists on why the Visiting Faculty Certificate is nonrenewable and limited to one year. The Visiting Faculty Certificate’s legislative history does

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<sup>122</sup>OHIO ADMIN. CODE 4731:6-32 (2005); OHIO REV. CODE ANN. § 4731.293 (LexisNexis 2005).

<sup>123</sup>OHIO ADMIN. CODE 4731:6-32 (2005); OHIO REV. CODE ANN. § 4731.293 (LexisNexis 2005).

<sup>124</sup>OHIO ADMIN. CODE 4731:6-32 (2005); OHIO REV. CODE ANN. § 4731.293 (LexisNexis 2005). “A visiting faculty certificate may be issued to an applicant holding a current, unrestricted license to practice medicine and surgery in another state or country if the applicant has been appointed to serve in this state on the academic staff of an [Liaison Committee on Medical Education] or [American Osteopathic Association] accredited school.” OHIO ADMIN. CODE 4731:6-32 (2005). The regulation also amplifies OHIO REV. CODE ANN. § 4731.293 (LexisNexis 2005) which requires applicants to demonstrate that they are proficient English speakers. OHIO ADMIN. CODE 4731:6-32 (2005).

<sup>125</sup>OHIO ADMIN. CODE 4731:6-32 (2005); OHIO REV. CODE ANN. § 4731.293 (LexisNexis 2005). “A current, unrestricted license is a license or other authority granted by the appropriate entity or governmental body which lawfully permits the applicant to practice all branches of medicine . . . without governmental restriction.” OHIO ADMIN. CODE 4731:6-32 (2005).

<sup>126</sup>A “visiting-faculty doctor” is this note’s term for a doctor practicing or eligible to practice in Ohio or another state under a Visiting Faculty Certificate or another state’s version of that license.

<sup>127</sup>OHIO ADMIN. CODE 4731:6-32 (2005); OHIO REV. CODE ANN. § 4731.293 (LexisNexis 2005). “The holder of a visiting faculty certificate may practice only as is incidental to teaching duties at the school, or at the teaching hospitals affiliated with the school.” OHIO ADMIN. CODE 4731:6-32 (2005).

<sup>128</sup>OHIO ADMIN. CODE 4731:6-32 (2005); OHIO REV. CODE ANN. § 4731.293 (LexisNexis 2005). “An individual may be granted only one visiting faculty certificate and is ineligible to apply for its renewal or a second visiting faculty certificate.” OHIO ADMIN. CODE 4731:6-32 (2005).



not explain why the legislature enacted these limitations; instead, the legislative history repeats the license's requirements.<sup>129</sup> The board minutes, however, leading up to and including the board's recommendation of the Visiting Faculty Certificate, show that the license's one-year limitation and nonrenewability concerned at least one board member. Board member Carol Rolfe asked whether the Visiting Faculty Certificate's one-year limit and nonrenewability were "realistic."<sup>130</sup> Board member Dr. Henry Cramletti responded that the Visiting Faculty Certificate "is not being considered to circumvent full licensure" and that it is "only available for those who are only going to be in Ohio for a set period of time, less than one year."<sup>131</sup> Dr. Cramletti added that "these physicians are carefully screened by the [medical] schools prior to . . . being invited to Ohio."<sup>132</sup> He did not, however, say why the state should require these "carefully screened" doctors to complete the full-licensure requirements to practice in the state longer than one year.

Current board members also have offered ideas as to why the Visiting Faculty Certificate is nonrenewable.<sup>133</sup> For example, at the board's November 10, 2005 meeting, board president Dr. Patricia Davidson said that the "idea behind the [Visiting Faculty Certificate] was to allow someone to come in and teach a new procedure."<sup>134</sup> Dr. Davidson was not on the board when it recommended that the legislature create the Visiting Faculty Certificate.<sup>135</sup> Regardless, her statement is incorrect or she misspoke because Ohio already has a different license for the situation that Dr. Davidson described: the Special Activity Certificate.<sup>136</sup> That

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<sup>129</sup>Legislative Service Commission Analysis, 119<sup>th</sup> General Assembly: House Bill 454, available at [http://han2.hannah.com/htbin/f.com/oh\\_ban\\_119:HB454.lsc](http://han2.hannah.com/htbin/f.com/oh_ban_119:HB454.lsc) (last visited Feb. 10, 2006).

<sup>130</sup>The State Medical Board of Ohio, *Meeting Minutes*, August 8, 1990, 5167 at 5176 [hereinafter *Meeting Minutes*, August 1990] (quoting the meeting minutes) (on file with author).

<sup>131</sup>*Id.*

<sup>132</sup>*Id.*

<sup>133</sup>*Compare* The Medical Board of California's Special Programs Task Force, *Meeting Minutes*, August 30, 2005 (discussing the legislature's intent in creating California's license similar to the Visiting Faculty Certificate) (on file with author). Committee member Dr. Richard Fantozzi believes that the license's purpose is to allow foreign doctors "with a special expertise to come to California and educate staff or students on something unique," and not an "avenue to bring in individuals with only the minimum level of training." *Id.* Contrarily, Dr. Neil Parker, an audience member, said that he believes that the legislature's intent "was to bring in internationally trained appointees with special expertise and keep them on . . . [the] faculty [of the institution to which they were appointed] if they proved to be appropriately qualified." *Id.* Dr. Parker added that "if these [doctors] are truly outstanding individuals, it would not be beneficial to the citizens of California to lose them and send them back to their home countries." *Id.*

<sup>134</sup>The State Medical Board of Ohio, *Meeting Minutes*, November 10, 2005, 15465 at 15482 [hereinafter *Meeting Minutes*, November 2005] (quoting the meeting minutes), available at <http://med.ohio.gov/pdf/Minutes/11-05.pdf>.

<sup>135</sup>*Meeting Minutes*, October 1990, *supra* note 2.

<sup>136</sup>OHIO ADMIN. CODE 4731-6-33 (2005).

license allows an applicant to practice medicine in the state “in conjunction with a special activity, program, or event taking place” in Ohio and requires additional education or training.<sup>137</sup> Board member Dr. Anita Steinbergh gave another reason for keeping the Visiting Faculty Certificate nonrenewable.<sup>138</sup> She conclusorily said that doctors “shouldn’t be doing patient care if they don’t meet licensure requirements.”<sup>139</sup> Dr. Steinbergh did not, however, say why the state should require visiting-faculty doctors to complete the full-licensure requirements.<sup>140</sup>

Compare Drs. Steinbergh’s and Cramletti’s conclusory statements with the arguments of doctors who tried to prohibit practitioners like chiropractors from practicing medicine in the first half of the nineteenth century. Those doctors argued that the medical profession was “justified in objecting to the various cults [e.g., chiropractors] . . . because of their serious lack of education.”<sup>141</sup> Although the medical profession’s intent to destroy chiropractors was obvious,<sup>142</sup> it was able to level a substantive criticism — i.e., that the “various cults” lacked education<sup>143</sup> — against those practitioners whom it sought to stop from practicing. Drs. Steinbergh and Cramletti, however, cannot make the same or similar argument against visiting-faculty doctors, so they rely on a truism — i.e., licensure itself makes a doctor competent.<sup>144</sup> If the board does not know why the Visiting Faculty Certificate is nonrenewable or cannot offer a substantive reason why it should remain nonrenewable, Ohio must make it renewable.

### III. POSSIBLE ARGUMENTS AGAINST MAKING THE VISITING FACULTY CERTIFICATE RENEWABLE

Those against making the Visiting Faculty Certificate renewable might argue that it must remain nonrenewable for three reasons: (1) to protect patients, (2) to manage the risk that a visiting-faculty doctor will injure a patient, and (3) to prevent the board and state from being liable for issuing a license that does not determine whether a doctor is qualified. The only valid argument, however, against making the Visiting Faculty Certificate renewable is that allowing visiting-faculty doctors to practice in the state indefinitely would undercut the fully-licensed doctors’ health care monopoly and, thus, drive down health care costs.<sup>145</sup> If this argument is true, it does not need to be discredited because lower health care costs are, presumably, a

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<sup>137</sup>OHIO ADMIN. CODE 4731-6-33 (2005). “A special activity certificate may be issued to an applicant seeking to practice medicine and surgery or osteopathic medicine and surgery in conjunction with a special activity, program, or even taking place in this state.” *Id.*

<sup>138</sup>*Meeting Minutes*, November 2005, *supra* note 134.

<sup>139</sup>*Id.*

<sup>140</sup>*Id.*

<sup>141</sup>AMERINGER, *supra* note 31, at 26.

<sup>142</sup>*See supra* text accompanying note 55.

<sup>143</sup>AMERINGER, *supra* note 31, at 26.

<sup>144</sup>*Meeting Minutes*, November 2005, *supra* note 134; *Meeting Minutes*, August 1990, *supra* note 130.

<sup>145</sup>*Cf. GROSS, supra* note 11, at 24.

good thing.<sup>146</sup> Therefore, this section will discuss and discredit only the first three arguments.

*A. An Argument: The Visiting Faculty Certificate is Nonrenewable to Protect Patients*

Whatever the legislature's reason for making the Visiting Faculty Certificate nonrenewable, one thing is clear: it is not nonrenewable to protect patients. To argue that doctors who are not fully licensed endanger the public, while allowing them to practice in the state for one year is illogical. If the legislature was concerned about visiting-faculty doctors injuring patients, it would not allow them to practice in the state at all. The fact is, most, if not all, visiting-faculty doctors are more qualified than newly-licensed doctors. As evidence of how qualified these doctors are, consider whether a medical school would appoint visiting-faculty doctors to its faculty if it did not believe that they were qualified.<sup>147</sup> Similarly, would the board allow visiting-faculty doctors to practice in the state without having passed an exam, if it did not think that they had a mitigating qualification, like experience? A License by Examination, on the other hand, requires a doctor to have only minimal experience.<sup>148</sup> Therefore, under Ohio's medical-licensing laws, the board illogically may issue a "license to someone with a short track record and a lot of paper [i.e., a newly-licensed doctor who only has passed the board's exam] and not license someone with a long track record and little paper" (i.e., a visiting-faculty doctor).<sup>149</sup>

*B. An Argument: The Visiting Faculty Certificate is Nonrenewable to Manage Risk*

Another reason that the legislature might have limited the Visiting Faculty Certificate to one year is to manage the risk that a visiting-faculty doctor will injure a patient. Risk is the "uncertainty of a result, happening, or loss; the chance of injury, damage, or loss; [especially], the existence and extent of the possibility of harm."<sup>150</sup>

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<sup>146</sup>See Dan Balz, *Governors Challenge Cuts in National Guard; Leavitt Says States Unprepared for Pandemic*, THE WASHINGTON POST, Feb. 26, 2006, at A06 (reporting that the Secretary of the United States Department of Health and Human Services Michael Leavitt told the National Governors Association that "spiraling costs for health care is gobbling up a growing percentage of the nation's gross domestic product" and if "[l]eft unchecked, those trends will cost the United States its leadership role in the global economy") (quoting the article).

<sup>147</sup>See *supra* Part II.F.

<sup>148</sup>OHIO ADMIN. CODE 4731:6-14 (2005); see also OHIO REV. CODE 4731.091 (LexisNexis 2005). "'Graduate medical education' means education received through one of the following: (a) an internship or residency program . . . at an institution with a[n accredited] residency program . . .; (b) a clinical fellowship program . . . at an institution with a[n accredited] residency program . . . in a clinical field the same as or related to the clinical field of the fellowship program." OHIO ADMIN. CODE 4731:6-14 (2005); see also OHIO REV. CODE 4731.091 (LexisNexis 2005).

<sup>149</sup>The State Medical Board of Ohio, *Meeting Minutes*, July 11, 1990, 5139 at 5151-5152 [hereinafter *Meeting Minutes*, July 1990] (quoting the meeting minutes, in which board member Dr. Carla O'Day made this remark, that refer to a "temporary license," but discuss "visiting physicians") (on file with author). Regardless of what license the board was discussing, the argument is applicable to the Visiting Faculty Certificate.

<sup>150</sup>BLACK'S LAW DICTIONARY 1333 (8th ed. 1999).

To become a fully-licensed doctor in Ohio, an applicant must pass an exam.<sup>151</sup> Passing an exam decreases the risk — i.e., the “uncertainty” — that a doctor might injure a patient by establishing that an individual meets certain, usually entry-level, qualifications.<sup>152</sup> Without knowing anything else about two doctors, one who has passed an exam and one who has not, the risk that the doctor who has not passed an exam will injure a patient is greater because more uncertainty surrounds that doctor.<sup>153</sup> Requiring an applicant to pass an exam, however, is only one way to decrease risk.<sup>154</sup> Other ways of decreasing risk include considering a doctor’s achievements and experience.<sup>155</sup> Because visiting-faculty doctors must receive a faculty appointment to be eligible for a Visiting Faculty Certificate, these doctors are not fresh out of medical school; instead, they are experienced doctors, respected in their profession.<sup>156</sup> So, the risk — again, the “uncertainty” — that a visiting-faculty doctor will injure a patient is minimal considering the experience that they have.<sup>157</sup> Some patients might consider that risk so low that they would prefer being treated by an experienced visiting-faculty doctor, rather than a newly-admitted doctor who

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<sup>151</sup>See *supra* Part II.C.

<sup>152</sup>*Cf.* GROSS, *supra* note 11, at 16 (noting that those who favor licensure argue that “[b]y establishing and maintaining quality standards for practitioners through selection, examination, and disciplining of licenses, licensing agencies prevent the unscrupulous and the unqualified from practice”). *Cf.* The Uniform CPA Examination, [http://www.cpa-exam.org/cpa/computer\\_faqs\\_1.html](http://www.cpa-exam.org/cpa/computer_faqs_1.html) (stating that the CPA exam’s purpose is “to admit individuals into the accounting profession only after they have demonstrated the *entry-level* knowledge and skills”) (author’s emphasis) (last visited Feb. 10, 2006).

<sup>153</sup>*Cf.* GROSS, *supra* note 11, at 5 (arguing that a “credential is a public testimony about an individual’s qualifications that the person is a good credit risk . . . or that the person has passed an examination” and that “[c]redentials *inform* people who do not know the credentialed individual but who do know the public body that does the credentialing”) (emphasis in original).

<sup>154</sup>Exams are not only a way of decreasing risk, but also a way for medical boards to control the number of doctors it allows into the profession by manipulating the exam’s pass rate. GROSS, *supra* note 11, at 25. Interestingly, when the author was collecting information on the United States Medical Licensing Exam, the author sent an email to the National Board of Medical Examiners which administers the exam asking for the exam’s average pass rate. The author received the following reply: “Information on performance is available and provided only to the individual medical school. This data is not provided to any other party.” E-mail from Applicant Services, the National Board of Medical Examiners, to Austin McGuan, student, Cleveland-Marshall College of Law, (Nov. 29, 2005, 5:53 PM DST) (on file with author).

<sup>155</sup>*Cf.* GROSS, *supra* note 11, at 16, 154 (citing Hogan, D. B., *The Regulation of Psychotherapists, Volume I: A Study in the Philosophy and Practice of Professional Regulation*, (1979), who “found work experience to be an excellent predictor of competence,” but not expressly mentioning a cause-and-effect relationship between these qualities and decreasing risk).

<sup>156</sup>See *supra* Part II.F.

<sup>157</sup>BLACK’S, *supra* note 150.

has only passed an exam.<sup>158</sup> Therefore, when managing the risk that a doctor will injure a patient, considering a doctor's experience is at least as effective as requiring a doctor to pass an exam.

*C. An Argument: The Board May Be Held Liable for Issuing a Renewable Visiting Faculty Certificate to a Doctor Who Injures a Patient*

Those against making the Visiting Faculty Certificate renewable also might be concerned that a court will hold the state, the board, or both liable to a patient injured by a visiting-faculty doctor. For example, a patient might claim that the board should be liable for issuing a medical license that did not determine whether the doctor was qualified. Because the board has not taken any disciplinary action against visiting-faculty doctors in the fourteen years that Ohio has had the license, the chances of one of these doctors harming a patient is low.<sup>159</sup> Regardless, Ohio courts grant the board and the legislature much deference to, respectively, issue regulations and enact legislation.<sup>160</sup> In *Reynolds v. State*, the Supreme Court of Ohio held that the "state cannot be sued for its legislative or judicial functions or the exercise of an executive or planning function involving the making of a basic policy decision which is characterized by the exercise of a high degree of official judgment or discretion."<sup>161</sup>

Applying that holding to the current or an amended, renewable Visiting Faculty Certificate regulation or law, Ohio courts would not allow an injured patient to recover from the board or the state for, respectively, issuing or enacting that license. What makes someone qualified to practice medicine is subjective. For instance, looking at the full-licensure requirements, the board must think that exams, training, and education make someone qualified.<sup>162</sup> Many patients, on the other hand, look at other factors when determining whether a doctor is qualified, including "whether the physician communicates a personal interest in the patient, whether he listens carefully, whether he shows a sympathetic concern and provides feedback, and whether he appears to know what he is doing."<sup>163</sup> Because what makes someone qualified to practice medicine is subjective, the board is making a "basic policy decision . . . characterized by the exercise of a high degree of official judgment" when it recommends a license's requirements to the legislator or issues licensure

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<sup>158</sup>*Cf. Meeting Minutes*, July 1990, *supra* note 149 (this argument is similar to Dr. O'Day's comment about licensing those doctors who have little experience, while not licensing those doctors with a whole "track record").

<sup>159</sup>E-mail from Jean Wehrle, Chief of Staff, State Medical Board of Ohio, to Austin McGuan, student, Cleveland-Marshall College of Law (Nov. 4, 2006, 8:51 AM DST) (on file with author).

<sup>160</sup>*Reynolds v. State*, 471 N.E.2d 776 (Ohio 1984).

<sup>161</sup>*Id.* at 778. The Supreme Court of Ohio also held that "once the decision has been made to engage in a certain activity or function, the state may be held liable in the same manner as private parties for the negligence of the actions of its employees." *Id.* So, for example, the board could be liable for issuing a Visiting Faculty Certificate to a doctor whom a medical institution did not appoint to its faculty.

<sup>162</sup>*See supra* Part II.C.

<sup>163</sup>GROSS, *supra* note 11, at 18.

regulations.<sup>164</sup> Also, the state is exercising its legislative function when it enacts a licensure law. Therefore, a court will not hold the board or the state liable for, respectively, issuing or enacting the current or an amended, renewable Visiting Faculty Certificate regulation or law.

#### IV. THE ONE-YEAR, NONRENEWABLE VISITING FACULTY CERTIFICATE NEGATIVELY AFFECTS OHIO

Having determined that the arguments against making the Visiting Faculty Certificate renewable are unfounded, the license's negative impact on Ohio must be considered. By driving away foreign doctors and discouraging them from coming to the state, the one-year, nonrenewable Visiting Faculty Certificate causes Ohio to lose federal grants, state and local tax revenue, medical-research expertise, and highly-desired foreign doctors.

##### A. *The Visiting Faculty Certificate's Cost: Lost Federal Grants*

Federal grants are important to a strong economy. Because most research funding comes from outside of the state, increased research spending creates an "increased knowledge base and direct stimulus to Ohio's economy."<sup>165</sup> For example, between 2001 and 2004, sixty-nine companies were established in the state because of university research.<sup>166</sup> According to Dr. Edward Hundert, Case's former President, "attracting more research grants can provide a better economy, attract new businesses along with the capital and the people that come with them, create new jobs and improve the quality of life in [Northeast Ohio] and the state."<sup>167</sup>

Ohio loses federal grants because the Visiting Faculty Certificate discourages doctors from coming to and staying in the state. Since Ohio created the Visiting Faculty Certificate in 1992,<sup>168</sup> the board has issued sixty-seven of those licenses to sixty-five doctors.<sup>169</sup> According to a database of "federally funded biomedical research projects,"<sup>170</sup> of the sixty-five doctors who have received Visiting Faculty Certificates, five received federal grants.<sup>171</sup> At least one of those five doctors

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<sup>164</sup>*Reynolds*, 471 N.E.2d at 778.

<sup>165</sup>Jennifer Gonzalez, *Research Paying Off for Ohio Universities*, THE PLAIN DEALER (Cleveland, Ohio), Jan. 20, 2006, at B1.

<sup>166</sup>*Id.*

<sup>167</sup>Hundert, *supra* note 8.

<sup>168</sup>OHIO REV. CODE ANN. § 4731.293 (LexisNexis 2005).

<sup>169</sup>The State Medical Board of Ohio, *Visiting Medical Faculty Certificates Issued, 1992-Present* [hereinafter *Visiting Medical Faculty Certificates Issued*] (on file with author).

<sup>170</sup>ERA Commons: Computer Retrieval of Information on Scientific Projects, <http://crisp.cit.nih.gov/> (last visited Feb. 10, 2006). This database, maintained by the Office of Extramural Research at the National Institutes of Health, includes projects funded by the National Institutes of Health and other organizations. *Id.* The author searched on this website under the names of all doctors who received Visiting Faculty Certificates. *Visiting Medical Faculty Certificates Issued*, *supra* note 169.

<sup>171</sup>Drs. Syed Shujaat Ali, Kejian Chen, Rongming Xu, Sanjaya Dhoj Joshi, Derek Raghavan, and Michael Maes received federal grants. ERA Commons, *supra* note 170.

received federal grants, totaling \$420,700,<sup>172</sup> after leaving Ohio.<sup>173</sup> Although that amount might seem trivial, it does not include how much federal funding never came to Ohio because the Visiting Faculty Certificate discouraged doctors from coming to the state. To get an idea of how many doctors that license might discourage from coming to Ohio, consider board member Dr. Anant Bhati's comment from the May 2004 board meeting: "[I] get one call a month from the University of Cincinnati, who (sic) wants to hire someone" who does not meet the full-licensure requirements.<sup>174</sup>

*B. The Visiting Faculty Certificate's Cost: Lost Tax Revenue*

Regardless of whether doctors receive federal grants, their presence in Ohio is an important contribution to the state and local tax bases. According to an online database of licensed Ohio professionals,<sup>175</sup> of the sixty-five doctors who received Visiting Faculty Certificates, fifty-six have either left or no longer practice in Ohio.<sup>176</sup> The national average for a starting salary of a radiologist is \$160,000.<sup>177</sup> If

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<sup>172</sup>After determining which doctors left Ohio with federal grants or received federal grants after leaving Ohio, the author searched under this database to determine the amounts of those federal grants. NIH Extramural Awards by State and Foreign Site, <http://grants1.nih.gov/grants/award/state/state.htm> (last visited Feb. 10, 2006). Dr. Joshi's two grants, *supra* note 171, totaled \$420,700. *Id.* The author could not find Dr. Maes' grant in this database, so the author excluded him from the calculation. *Id.*

<sup>173</sup>Dr. Joshi, whose Visiting Faculty Certificate expired on July 30, 1999, received two federal grants for September 30, 2004 through August 31, 2006. *Visiting Medical Faculty Certificates Issued, supra* note 169; ERA Commons, *supra* note 170. Dr. Maes, whose Visiting Faculty Certificate expired on August 30, 1995, received a federal grant for fiscal year 1995. *Visiting Medical Faculty Certificates Issued, supra* note 169; ERA Commons, *supra* note 170. Although a Dr. Xu with a similar first name as the Dr. Xu to whom the board issued a Visiting Faculty Certificate received federal grants, the author could not determine whether they were the same doctor. *Visiting Medical Faculty Certificates Issued, supra* note 169; ERA Commons, *supra* note 170. Therefore, the author excluded Dr. Xu from this calculation. Dr. Raghavan, whose Visiting Faculty Certificate began on May 27, 2004, received a federal grant for December 1, 2003 through Nov. 30, 2004 and received another license after his Visiting Faculty Certificate expired. *Visiting Medical Faculty Certificates Issued, supra* note 169; ERA Commons, *supra* note 170. Although Dr. Chen received his federal grant after his Visiting Faculty Certificate expired, this database showed that he still remained in Ohio when he received his federal grant. *Visiting Medical Faculty Certificates Issued, supra* note 169; ERA Commons, *supra* note 170. Because the Visiting Faculty Certificate did not discourage Drs. Raghavan and Chen from coming to or remaining in Ohio, they will not be included in this calculation of lost federal grants.

<sup>174</sup>The State Medical Board of Ohio, *Meeting Minutes*, May 12, 2004, 14087 at 14137 [hereinafter *Meeting Minutes*, May 2004] (quoting the meeting minutes) available at <http://med.ohio.gov/pdf/minutes/05-04.pdf>.

<sup>175</sup>Ohio eLicense Center, <https://license.ohio.gov/lookup/default.asp> (last visited Feb. 10, 2006) (under "Division," select "Medical Board").

<sup>176</sup>Of the seven visiting-faculty doctors who still have Ohio licenses, one is practicing under a Visiting Faculty Certificate, two have medical licenses pending, and three have active medical licenses. *Id.*

<sup>177</sup>Physicians Search, <http://www.physicianssearch.com/physician/salary1.html> (last visited Feb. 10, 2006).

those fifty-six doctors who did not receive another Ohio medical license have left Ohio and have continued to practice medicine,<sup>178</sup> they have taken an estimated \$9 million of income with them.<sup>179</sup> If those doctors had practiced and lived in Cleveland, the city would have taxed them at its two-percent income-tax rate.<sup>180</sup> Therefore, those doctors' departures cause an estimated \$193,000 annual income-tax loss to Cleveland.<sup>181</sup>

When doctors leave the state, Ohio also loses tax revenue. Under 2004 Ohio income-tax rates, a doctor who makes \$160,000 and is married with two children would pay \$8,300 in Ohio income tax.<sup>182</sup> Multiplying that estimated \$8,300 income-tax loss per doctor<sup>183</sup> by the fifty-six doctors who have either left or no longer practice in Ohio<sup>184</sup> yields an estimated \$465,214 annual income-tax loss to Ohio.<sup>185</sup>

Again, although these amounts might seem trivial, they do not include the tax revenue that Cleveland and Ohio never collected because the one-year, nonrenewable Visiting Faculty Certificate discouraged doctors from coming to the city and the state. These amounts also do not include visiting-faculty doctors' contributions to the state and local economies through purchases of goods and

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<sup>178</sup>This calculation is based on the assumptions that there is a constant need of doctors in Ohio and that doctors who have left Ohio after their Visiting Faculty Certificates expired would have remained in Ohio if the Visiting Faculty Certificate was renewable.

<sup>179</sup>The author multiplied the fifty-six doctors who no longer have Ohio medical licenses, *supra* note 176, by the \$160,000 average starting salary of radiologist, Physicians Search, *supra* note 177, to arrive at an estimated \$9,180,000 of income that has left Ohio because of the one-year, nonrenewable Visiting Faculty Certificate.

<sup>180</sup>Central Collection Agency: Division of Taxation: Department of Finance: City of Cleveland, <http://www.ccatax.ci.cleveland.oh.us/> (last visited Feb. 10, 2006) (click on "Tax Rates" on the left side of the web page).

<sup>181</sup>The author multiplied the approximate \$9,180,000 of income that has left Ohio, *supra* note 179, by Cleveland's 2% income-tax rate, *supra* note 180, to arrive at an estimated \$192,904 of tax-revenue that Cleveland loses annually because of the one-year, nonrenewable Visiting Faculty Certificate.

<sup>182</sup>Assuming that the doctor has no federal adjusted-gross-income deductions, and has no state deductions or credits other than the personal-and-dependant exemptions and the exemptions credit, the author subtracted the \$5,200 of personal-and-dependant exemptions (4 x \$1,300) from the doctor's \$160,000, Physicians Search, *supra* note 177, of federal adjusted gross income to arrive at this doctor's estimated taxable income of \$154,800. Ohio Department of Taxation, <http://dw.ohio.gov/tax/dynamicforms/> (last visited Feb. 10, 2006) (select "Individual Income Tax" under "Tax Type," and then click on "Ohio Income Tax Rates - 1972-2004" and "Ohio Income Tax Return - 2004"). The author then subtracted \$100,000 (from the tax table) and multiplied the difference by 6.9% to arrive at \$3,781. The author then added that amount to \$4,602.20 (from the tax table) and subtracted \$80 of exemptions credit (4 x \$20) to arrive at an estimated \$8,300 of tax revenue, per doctor, that Ohio loses annually because of the one-year, nonrenewable Visiting Faculty Certificate. *Id.*

<sup>183</sup>*See supra* text accompanying note 182.

<sup>184</sup>*See supra* text accompanying note 179.

<sup>185</sup>This calculation is based on the assumptions that a constant need for doctors exists in Ohio and that doctors who have left Ohio after their Visiting Faculty Certificates expired would have remained in Ohio if the Visiting Faculty Certificate was renewable.



services. Regardless of how insubstantial these amounts might seem, given the poor economic condition of the city and the state, they are losses that Cleveland and Ohio cannot afford.<sup>186</sup> To increase the income revenue of Cleveland and Ohio and the money injected into the state and local economies, Ohio must make the Visiting Faculty Certificate renewable.

*C. The Visiting Faculty Certificate's Cost: Lost Medical Expertise*

Besides contributing tax revenue to Ohio and its local governments, visiting-faculty doctors, who come to the state to do research, are helping Ohio establish itself as a bio-tech hub.<sup>187</sup> Ohio is fortunate to have a "broad mix" of the universities, federal laboratories, and research organizations that drive research.<sup>188</sup> Compared to the rest of the nation, however, Ohio has a low number of technologically-trained and highly-educated workers, critical to sustaining and developing a technology-based economy.<sup>189</sup> In other words, Ohio needs "more knowledge to better compete in the new economy."<sup>190</sup> In February 2002, Ohio's Governor launched the ten-year, \$1.1 billion "Third Frontier Project," which is committed to "expanding Ohio's high-tech research capabilities."<sup>191</sup> In 2004, Northeast Ohio's universities, hospitals, and research centers invested \$901.5 million in research.<sup>192</sup> And, in November 2005, Ohio voters amended the state's constitution to allow the state to raise \$500 million to finance high-tech research.<sup>193</sup> For Ohio to capitalize on these substantial investments, it must "develop, retain, and expand the state's workforce to ensure a sufficient intellectual, entrepreneurial, and technical talent base."<sup>194</sup> To attract and retain visiting-faculty doctors — many of whom are "world-class" research doctors — Ohio must make the Visiting Faculty Certificate renewable.<sup>195</sup>

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<sup>186</sup>See *supra* Part I.

<sup>187</sup>Op-Ed, *The Keys: Innovation and a Work Force*, THE PLAIN DEALER (Cleveland, Ohio), November 24, 2002, at H3.

<sup>188</sup>Technology Partnership Practice, Battelle Memorial Institute, *An Ohio Technology-Based Economic Development Strategy*, at xv (May 2002), available at <http://www.thirdfrontier.com/pdf/Battelle-041002.pdf>.

<sup>189</sup>*Id.* at ix, xii.

<sup>190</sup>Battelle Memorial Institute, *supra* note 188.

<sup>191</sup>The Ohio 3rd Frontier Project: Pioneering the 3rd Frontier of Knowledge and Information, <http://www.thirdfrontier.com/overview.asp> (last visited Feb. 10, 2006).

<sup>192</sup>Hundert, *supra* note 8.

<sup>193</sup>Becky Gaylord and Julie Carr Smyth, *Taft Joins in Claiming Victory for Issue 1; 2nd Effort Pays Off*, THE PLAIN DEALER (Cleveland, Ohio), Nov. 9, 2005, at B1 (reporting that the amendment to the Ohio Constitution will allow the state to purchase stock in companies and sell bonds to raise \$500 million to finance high-tech research, \$1.35 billion for public works projects, and \$150 million to prepare industrial sites).

<sup>194</sup>Battelle Memorial Institute, *supra* note 188, at xvii.

<sup>195</sup>*Meeting Minutes*, November 2005, *supra* note 134.

*D. The Visiting Faculty Certificate's Cost: Doctor Shortages at Small, Rural Hospitals*

Visiting-faculty doctors, who are mostly foreigners,<sup>196</sup> are important not only to research institutions, but also to small, rural hospitals. Because American doctors usually prefer university hospitals and hospitals in large cities, foreign medical school graduates fill many of the residencies at small-town hospitals.<sup>197</sup> According to a former doctor at a small, rural hospital, “[t]he foreign-trained doctors who qualified tended to stay in the community . . . [and] [m]any who left went to other small communities where there was a need.”<sup>198</sup> Also, when “spots in medical centers were vacant, foreign-trained doctors often recruited [doctors] in their homelands to fill them.”<sup>199</sup> According to the *New England Journal of Medicine*, twenty-five percent of all doctors in the United States are foreign medical school graduates.<sup>200</sup> The number of American medical school graduates has remained almost constant since 1980, despite a population increase of fifty million.<sup>201</sup> As baby boomers retire, “the shortage of doctors will grow worse, creating even greater demand for [foreign] doctors.”<sup>202</sup> Ohio needs foreign doctors to come to the state to satisfy the current demand — and the inevitable future demand — for doctors in rural hospitals.

Visiting-faculty doctors can directly and indirectly decrease the doctor shortage at rural hospitals. Although visiting-faculty doctors probably will not practice at rural hospitals,<sup>203</sup> they can indirectly ease the doctor shortage at rural hospitals by recruiting other foreign doctors who are eligible for full licensure to fill vacancies at Ohio’s rural hospitals. Visiting-faculty doctors can also directly ease the doctor shortage at rural hospitals. Under the current Visiting Faculty Certificate, visiting-faculty doctors who complete the full-licensure requirements while practicing in the state might be willing to practice at rural hospitals once their appointments end. Also, under an amended Visiting Faculty Certificate, Ohio could allow visiting-faculty doctors to practice at rural hospitals once their faculty appointments end, without requiring them to meet full-licensure requirements.<sup>204</sup> Whether these

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<sup>196</sup>*Visiting Medical Faculty Certificates Issued*, *supra* note 169.

<sup>197</sup>Dr. Norman M. Weil, Op-Ed, *U.S. Must Build More Medical Schools*, THE PLAIN DEALER (Cleveland, Ohio), December 28, 2005, at B9.

<sup>198</sup>*Id.*

<sup>199</sup>*Id.*

<sup>200</sup>*Id.*

<sup>201</sup>*Id.*

<sup>202</sup>*Id.*

<sup>203</sup>Visiting-faculty doctors’ practice must be tied to the medical institution that appoints them to its faculty. OHIO ADMIN. CODE 4731:6-32 (2005); OHIO REV. CODE ANN. § 4731.293 (LexisNexis 2005).

<sup>204</sup>A precedent exists for relaxing licensure requirements for foreign doctors who were willing to practice at hospitals with doctor shortages. Medical boards have ignored citizenship requirements or lowered the exam’s passing score for those doctors, usually foreigners, who would work in “less desirable settings or in geographic areas of high need.” GROSS, *supra* note 11, at 25. See, e.g., N.C. GEN. STAT. § 90-12 (2005) (allowing North Carolina’s medical

approaches ease the doctor shortage at rural hospitals is contingent on Ohio attracting visiting-faculty doctors to the state. Therefore, to eliminate the doctor shortage at rural hospitals, Ohio must attract visiting-faculty doctors to the state by making the Visiting Faculty Certificate renewable.

#### V. OHIO MUST MAKE THE VISITING FACULTY CERTIFICATE RENEWABLE

By making the Visiting Faculty Certificate renewable, Ohio will not only become competitive in recruiting foreign doctors, but it will also make it easier for the state to retain them once they have come to Ohio. This section describes other states' visiting-faculty licenses and proscribes changes to the Visiting Faculty Certificate.

##### A. Other States' Visiting-Faculty Licenses

Unlike Ohio's one-year, nonrenewable Visiting Faculty Certificate, other states' visiting-faculty licenses are renewable or last indefinitely. Foreign doctors are more likely to come to a state that will allow them to practice beyond one year than a state, like Ohio, that limits their practice to only one year. North Carolina, Michigan, and California each offer a license similar to the Visiting Faculty Certificate, which lasts longer than one year. When Ohio decides to make the Visiting Faculty Certificate renewable, it should consider these states' licenses.

##### 1. North Carolina's Medical School Faculty License

The North Carolina Medical Board (the medical board) may issue limited licenses whenever it believes that the "conditions of the locality where the applicant resides . . . render it advisable."<sup>205</sup> That authority allows the medical board to modify the state's full-licensure requirements and to allow a limited license's holder to practice within the area it designates.<sup>206</sup> The medical board has issued two relevant licenses under North Carolina's limited-license statute: (1) a License for Medical School Faculty,<sup>207</sup> and (2) a Certificate of Registration for a Visiting Professor.<sup>208</sup>

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board to modify the licensure requirements "whenever in its opinion the conditions of the locality . . . render it advisable").

<sup>205</sup>N.C. GEN. STAT. § 90-12 (2005). The medical board "may, whenever in its opinion the conditions of the locality where the applicant resides are such as to render it advisable, make any modifications of the requirements [of North Carolina's medical-licensing statutes] as in its judgment the interests of the people living in that locality demand, and may issue to the applicant a special license, to be entitled a "Limited License," authorizing the holder of the limited license to practice medicine and surgery within the limits only of the district specifically described therein." *Id.*

<sup>206</sup>*Id.*

<sup>207</sup>21 N.C. ADMIN. CODE 32B.0801 (2005).

<sup>208</sup>21 N.C. ADMIN. CODE 32B.0701-04 (2005). "A written request for the Certificate of Registration for a Visiting Professor shall come from the dean of the medical school to which the applicant is seeking appointment. This request shall state the qualifications, positions responsibilities, and length of appointment of the visiting professor for whom the request is made." *Id.* "The visiting professor applicant must furnish proof of medical licensure in another state or foreign country by submitting a letter from the licensing agency indicating the status of the applicant's license." *Id.* "The practice of the visiting professor is limited to the institution requesting the Certificate of Registration." *Id.*

Because the Certificate of Registration lasts only one year,<sup>209</sup> it is not the license to which Ohio should compare the Visiting Faculty Certificate. The License for Medical School Faculty lasts indefinitely or, at least, as long as the faculty appointment.<sup>210</sup> Therefore, if Ohio wants to compete with North Carolina it must consider that state's License for Medical School Faculty.

To receive a Medical School Faculty License, an applicant must (1) have received a full-time faculty appointment at a North Carolina medical school; (2) have reports submitted to the medical board which indicate whether the applicant's license has been revoked, suspended, surrendered, or placed on probationary terms; and (3) have at least three recommendation letters submitted to the medical board on the applicant's behalf.<sup>211</sup> Two of those letters must be from doctors and one must be from someone the applicant has known for at least ten years.<sup>212</sup> Medical School Faculty Licenses allow their holders to practice within their employment on a North Carolina medical school's faculty.<sup>213</sup>

## 2. Michigan's Clinical Academic License

Michigan's Bureau of Health Professions may issue Clinical Academic Licenses to individuals who practice medicine only at an academic institution and in connection with their employment or contractual relationship with that institution.<sup>214</sup>

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<sup>209</sup>21 N.C. ADMIN. CODE 32B.0704 (2005). "The Certification (sic) of Registration shall be valid for one year." *Id.*

<sup>210</sup>The limited license statute, under which the medical board issues the Medical School Faculty License, expires when "its holder ceases to be a resident in the training program or obtains any other license to practice medicine issued by the board." N.C. GEN. STAT. § 90-12 (2005); 21 N.C. ADMIN. CODE 32B.0801 (2005).

<sup>211</sup>21 N.C. ADMIN. CODE 32B.0802-07 (2005). "To be eligible, the applicant shall have received full-time appointment as either a lecturer, assistant professor, associate professor or full professor at one of the following medical schools: (1) Duke University School of Medicine; (2) University of North Carolina at Chapel Hill School of Medicine; (3) Bowman Gray School of Medicine; and (4) East Carolina University School of Medicine. The applicant must submit verification and details of the appointment signed by the Dean or Acting Dean of the Medical School in which the applicant is to practice." 21 N.C. ADMIN. CODE 32B.0802 (2005).

<sup>212</sup>21 N.C. ADMIN. CODE 32B.0807 (2005). "Two of the letters must be from physicians. One of the letters must be from someone who has known the applicant for a period of ten years." *Id.*

<sup>213</sup>21 N.C. ADMIN. CODE 32B.0801 (2005). "The license for Medical School Faculty limits the practice of its holder to the confines of the physician's employment as a member of the medical faculty at one of the following North Carolina medical schools: (1) Duke University School of Medicine; (2) University of North Carolina at Chapel Hill School of Medicine; (3) East Carolina University School of Medicine; and (4) Bowman Gray School of Medicine. This license will not be used to engage in a practice outside the realm of the medical school." *Id.*

<sup>214</sup>MICH. COMP. LAWS ANN. § 333.16182 (West 2005). Michigan's medical board "may grant the following types of limited licenses upon application by an individual or upon its own determination: . . . (c) Clinical academic, to an individual who practices the health profession only as part of an academic institution and only in connection with his or her employment or other contractual relationship with that academic institution." *Id.*

To receive a Clinical Academic License, an applicant must have graduated from an American or foreign medical school and completed the state's medical-degree requirements.<sup>215</sup> Additionally, a Michigan academic institution must have appointed the applicant to a teaching or research position.<sup>216</sup> The holder of a Clinical Academic License must practice at that academic institution, under a fully-licensed doctor's supervision.<sup>217</sup> A Clinical Academic License is renewable annually for five years.<sup>218</sup>

### 3. California's Certificate of Registration

California's Division of Licensing<sup>219</sup> (the division) may issue two licenses to doctors who do not meet the state's full-licensure requirements: (1) Certificates of Registration,<sup>220</sup> and (2) "Section 2111 guest physician" certificates.<sup>221</sup> While

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<sup>215</sup>MICH. ADMIN. CODE r.338.2327a (2005). "That he or she has either graduated from a medical school which is located in the United States, its territories, the District of Columbia, or the Dominion of Canada and which is approved by the board or has graduated from a medical school that is located other than in the United States, its territories, the District of Columbia, or the Dominion of Canada and has completed the requirements for a degree in medicine as defined in r338.2301(c)." *Id.* See also MICH. ADMIN. CODE r.338.2301 (2005). "Completed the requirements for a degree in medicine" means that the applicant shall have graduated from a medical educational program which is not less than 130 weeks and which does not award credit for any course taken by correspondence. The medical educational program shall include a core curriculum which includes, at a minimum, all of the following courses in the basis sciences and clerkships in the clinical sciences: (i) Courses in the basis sciences, which shall include courses in all of the following: (A) Anatomy. (B) Physiology. (C) Biochemistry. (D) Microbiology. (E) Pathology. (F) Pharmacology and therapeutics. (G) Preventive medicine. (ii) Clerkships in the clinical sciences, which shall include clinical clerkships in all of the following: (A) Internal medicine. (B) General Surgery. (C) Pediatrics. (D) Obstetrics and gynecology. (E) Psychiatry. All core clinical clerkships shall be completed in a hospital or institution located in the United States, its territories, the District of Columbia or the Dominion of Canada that is approved by the board or in a hospital or institution that offers a postgraduate clinical training program in the content area of the clinical clerkship." *Id.*

<sup>216</sup>MICH. ADMIN. CODE r.338.2327a (2005). "That he or she has been appointed to a teaching or research position in an academic institution ." *Id.*

<sup>217</sup>MICH. COMP. LAWS ANN. § 333.17030 (West 2005). "A clinical academic license . . . shall require that the individual practice only for an academic institution and under the supervision of 1 or more physicians fully licensed under this part." *Id.*

<sup>218</sup>*Id.* "A clinical academic limited license . . . is renewable annually, but an individual shall not engage in the practice of medicine under 1 or more clinical academic licenses for more than 5 years." *Id.*

<sup>219</sup>CAL. BUS. & PROF. CODE § 2005 (West 2005). "The Division of Licensing shall have the responsibility for the following: (a) Approving undergraduate and graduate medical education programs. (b) Approving clinical clerkship and special programs and hospitals for such programs. (c) Developing and administering the physician's and surgeon's licensure examination. (d) Issuing licenses and certificates under the board's jurisdiction. (e) Administering the board's continuing medical education program. (f) Administering the student loan program." *Id.*

<sup>220</sup>CAL. BUS. & PROF. CODE § 2113 (West 2005).

<sup>221</sup>CAL. BUS. & PROF. CODE § 2111 (West 2005).

Certificates of Registration are available to foreign doctors whom a medical institution appoints to its faculty, “Section 2111 guest physician” certificates are available to foreign doctors who will participate in a fellowship.<sup>222</sup> Ohio already has a license similar to the “Section 2111 guest physician” certificate: the Training Certificate.<sup>223</sup> Accordingly, to make the Visiting Faculty Certificate competitive with California’s medical licenses, Ohio must consider that state’s Certificate of Registration.

The division may issue Certificates of Registration to applicants who meet four requirements. First, a California medical school’s dean must offer the applicant a full-time faculty position. Second, the applicant must have (1) been licensed for at least four years in another state or country whose licensure requirements are satisfactory to the division, (2) practiced in the United States for at least four years, or (3) completed a combination of that licensure and training.<sup>224</sup> Third, the head of the department in which the applicant will be working must certify that the applicant will be under his or her direction and will not be permitted to practice beyond the scope allowed by the division. Fourth, the medical school’s dean must demonstrate that the applicant is qualified for the position to which he or she is appointed.<sup>225</sup> A Certificate of Registration allows its holder to practice to the extent that it is “incident to and a necessary part of his or her duties” under the faculty position.<sup>226</sup>

A Certificate of Registration is valid for one year.<sup>227</sup> During that period, the division may require, as a condition to receiving the Certificate of Registration, that

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<sup>222</sup>The Medical Board of California’s Special Programs Task Force, *supra* note 133.

<sup>223</sup>OHIO ADMIN. CODE 4731:6-30 (2005) (Training Certificates).

<sup>224</sup>CAL. BUS. & PROF. CODE § 2113 (West 2005). “(a) Any person who does not immediately qualify for a physician’s and surgeon’s certificate under this chapter and who is offered by the dean of an approved medical school in this state a full-time faculty position may, after application to and approval by the Division of Licensing, be granted a certificate of registration. . . . To qualify for the certificate an applicant shall meet all of the following requirements: . . . (2) If the applicant is a graduate of a medical school other than in the United States or Canada, furnish documentary evidence satisfactory to the division that he or she has been licensed to practice medicine and surgery for not less than four years in another state or country whose requirements for licensure are satisfactory to the division, or has been engaged in the practice of medicine in the United States for at least four years in approved facilities, or has completed a combination of that licensing and training. If the applicant is a graduate of an approved medical school in the United States or Canada, furnish documentary evidence that he or she has completed a resident course of professional instruction as required in Section 2089.” *Id.*

<sup>225</sup>CAL. BUS. & PROF. CODE § 2113 (West 2005). “(3) The head of the department in which the applicant is to be appointed shall certify in writing to the division that the applicant will be under his or her direction and will not be permitted to practice medicine unless incident to and a necessary part of the applicant’s duties and approved by the division in subdivision (a) . . . (5) The dean of the medical school shall demonstrate that the applicant has requisite qualifications to assume the position to which he or she is to be appointed.” *Id.*

<sup>226</sup>*Id.* A certificate of registration allows someone to “engage in the practice of medicine only to the extent that the practice is incident to and a necessary part of his or her duties as approved by the division in connection with the faculty position.” *Id.*

<sup>227</sup>*Id.* “A certificate of registration is valid for one year after its issuance.” *Id.*

the doctor take the written exam required for full licensure.<sup>228</sup> Otherwise, the division may renew that license annually for five years.<sup>229</sup> The division also may condition renewal on passing an exam, obtaining a foreign medical certificate, or both.<sup>230</sup> The division may count the time that a doctor practices under a Certificate of Registration towards the post-graduate training requirement for full licensure and may waive the exam and foreign-medical-certificate requirements of full licensure.<sup>231</sup> The division, however, may condition waiving those requirements on passing the clinical competency exam.<sup>232</sup>

California's medical board is considering amendments to its Certificate of Registration. In November 2004, the medical board's Special Programs Committee created the Special Programs Task Force (the task force) to recommend whether the legislature should amend its special programs, which include the Certificate of Registration.<sup>233</sup> The task force recommended that the legislature allow the division to renew a Certificate of Registration for only three years, instead of five, unless the medical school shows that its appointee is progressing towards full licensure, in which case, the division may extend the license annually for two more years.<sup>234</sup> The task force also recommended a number of other amendments to California's current law.<sup>235</sup> Some of those amendments are related to informing the public about visiting-

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<sup>228</sup>*Id.* "During this period the division may require the registrant to take the written examination required for issuance of a physician's and surgeon's certificate." *Id.*

<sup>229</sup>*Id.* "If the registrant is not required to take the written examination in order to be issued a certificate of registration or has passed that examination, the certificate of registration may be renewed annually at the discretion of the division for a total period of five years from the date of issuance of the original certificate." *Id.*

<sup>230</sup>*Id.* "[T]he division, may in its discretion refuse to renew a certificate of registration if the registrant is a graduate of a medical school other than in the United States or Canada and has not, within two years after registration, been issued a certificate by the Educational Commission for Foreign Medical Graduates. The division may condition renewal on passing the written examination as described in this subdivision." *Id.*

<sup>231</sup>CAL. BUS. & PROF. CODE § 2113(d) (West 2005). "Notwithstanding any other provision of this law, the division may accept practice in an appointment pursuant to this section as qualifying time to meet the postgraduate training requirements in Section 2102, and may, in its discretion, waive the examination and the Educational Commission for Foreign Medical Graduates certification requirements specified in Section 2102 in the event the registrant applies for a physician's and surgeon's certificate." *Id.*; *see also* CAL. BUS. & PROF. CODE § 2102 (West 2005).

<sup>232</sup>CAL. BUS. & PROF. CODE § 2113(d) (West 2005). "As a condition to waiving any examination or the Educational Commission for Foreign Medical Graduates certification requirement, the division in its discretion, may require an applicant to pass the clinical competency examination referred to in subdivision (d) of Section 2135. The division shall not waive any examination for an applicant who has not completed at least one year in the faculty position." *Id.*; *see also* CAL. BUS. & PROF. CODE § 2135 (West 2005) (clinical competency exam).

<sup>233</sup>Medical Board of California's Special Programs Task Force, *supra* note 133.

<sup>234</sup>*Id.*

<sup>235</sup>*Id.*

faculty doctors: (1) requiring the visiting-faculty doctor to use the title “visiting faculty” on their name tags, (2) requiring the medical board to post information on its website describing a visiting-faculty doctor, and (3) requiring the visiting-faculty doctor to obtain signed acknowledgement from the patient stating that the patient understands that a visiting-faculty doctor is performing the services.<sup>236</sup> Other amendments are related to the discipline and review of visiting-faculty doctors, their supervisors, and the medical institution at which they are appointed: (1) subjecting all three of them to cutes and fines, letters of reprimand, and revocation, after being given the same due process to which licensees are entitled, (2) requiring visiting-faculty doctors to be accountable to the specialty in which they are practicing and proctored in the same way as new faculty, which includes review by the medical school’s medical staff, and (3) allowing the division to deny appointments to institutions with a history of abuse and violations.<sup>237</sup> The division also recommended that the board allow institutions, but not visiting-faculty doctors, to bill for visiting-faculty doctors’ services.<sup>238</sup> The task force passed a motion to draft the Certificate of Registration with these amendments and send that version to the division for its review.<sup>239</sup>

*B. A Renewable Visiting Faculty Certificate: A Competitive Ohio and Safer Patients*

Ohio is competitively-disadvantaged in recruiting visiting-faculty doctors because other states allow them to practice for longer than one year. To become competitive with other states, Ohio must amend the Visiting Faculty Certificate. Because medical research may take more than five years<sup>240</sup> and Ohio should keep visiting-faculty doctors in the state as long as possible,<sup>241</sup> Ohio must not enact a five-year limitation similar to Michigan’s or California’s.<sup>242</sup> Also, to protect patients, Ohio should not allow doctors to practice in the state indefinitely, like North Carolina,<sup>243</sup> without additional requirements to receive and maintain the license. Therefore, an amended, renewable Visiting Faculty Certificate must allow visiting-faculty doctors to practice in the state indefinitely while continuing to assure their competence.

In determining how to assure visiting-faculty doctors’ competence, Ohio must respect their professionalism and minimize the uncertainty of the board revoking their licenses. Ohio should not condition renewal, like California, upon receiving a

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<sup>236</sup>*Id.*

<sup>237</sup>*Id.*

<sup>238</sup>*Id.*

<sup>239</sup>*Id.*

<sup>240</sup>Leah Pappas and Dan Reinhard, *State Medical Board of Ohio Memorandum: Visiting Faculty Certificates*, Oct. 27, 2005 (on file with author).

<sup>241</sup>*See supra* Part IV.

<sup>242</sup>MICH. COMP. LAW § 338.17030 (2005); CAL. BUS. & PROF. CODE § 2113 (West 2005).

<sup>243</sup>21 N.C. ADMIN. CODE 32B.0801 (2005); *see also* N.C. GEN. STAT. § 90-12 (2005) (allowing the medical board to modify the “[q]ualifications of applicant for licensure” under N.C. GEN. STAT. § 90-9-11 (2005)).



foreign medical certificate at the board's discretion.<sup>244</sup> Because that certificate requires applicants to pass parts of the United States Medical Licensing Exam and a clinical-skills-assessment exam, it is similar to revoking the holder's license and making them meet the full-licensure requirements.<sup>245</sup> Alternatively, leaving renewal solely to the board's discretion favors more-connected doctors and creates uncertainty for the visiting-faculty doctors, which will discourage them from coming to the state. Also, because a medical institution might recruit a highly-acclaimed doctor to head a department,<sup>246</sup> Ohio should not require a medical institution to evaluate visiting-faculty doctors like it does other new medical staff, which California is considering.<sup>247</sup> Instead, to help assure patients' safety, Ohio should allow visiting-faculty doctors to practice in the state as long as they maintain a clean "track record," as set out in new board regulations, and meet the state's continuing medical education requirements.<sup>248</sup>

#### VI. ADDITIONAL PATIENT-SAFETY REQUIREMENTS FOR THE VISITING FACULTY CERTIFICATE

Even if Ohio does not make the Visiting Faculty Certificate renewable, the state must amend that license to assure the competence of visiting-faculty doctors before they practice in the state. To make patients safer, Ohio must require an applicant to meet four additional requirements<sup>249</sup> before receiving a Visiting Faculty Certificate: (1) the applicant graduated from a medical school recognized by the World Health Organization; (2) the licensing authorities in any state or country in which the applicant has practiced have not cited the applicant, and the applicant's license is in good standing; (3) the applicant has practiced long enough for the board to determine whether the applicant has a clean "track record;" and (4) the applicant has a board-determined clean "track record."<sup>250</sup> By enacting these additional requirements, Ohio will make patients safer.

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<sup>244</sup>CAL. BUS. & PROF. CODE § 2113 (West 2005).

<sup>245</sup>ECFMG 2006 Information Booklet, <http://www.ecfm.org/2006ib/2006ib.pdf> (last visited Feb. 9, 2006).

<sup>246</sup>See *infra* Part IX.A.

<sup>247</sup>Medical Board of California's Special Programs Task Force, *supra* note 133.

<sup>248</sup>OHIO ADMIN. CODE 4731:10-02 (2005). "Category 1 and category 2, CME shall be defined and identified within the programs certified by the respective state medical associations [the Ohio state medical association, the Ohio osteopathic association, and the Ohio podiatric medical association] and approved by the board. In a two year CME period, a licensee shall be required to earn a total of one hundred hours of CME, of which a minimum of forty hours shall be category 1 as certified by their respective state professional associations and approved by the board." *Id.* Because visiting-faculty doctors may only practice in Ohio for one year, the state's continuing-medical-education requirements probably do not currently apply to them.

<sup>249</sup>See *supra* Part II.E. (discussing current requirements for the Visiting Faculty Certificates).

<sup>250</sup>The fourth requirement would be similar to a one that the board considered for the interim license, which would have allowed applicants for Licenses by Endorsement to practice in Ohio until the board issued them licenses, with the medical-licensing statute that included the Visiting Faculty Certificate. *Meeting Minutes*, July 1990, *supra* note 149, at 5151 (quoting

Ohio also must make patients safer by encouraging them to be more vigilant in selecting their doctors. By allowing doctors who are not fully licensed to practice in the state, Ohio shifts some of the responsibility of assuring a doctor's competency from the board to patients.<sup>251</sup> Therefore, the board must inform patients when a visiting-faculty doctor is treating them so that they can decide whether they believe that the doctor is qualified. The state can accomplish this objective by adding requirements similar to those that California is considering: (1) requiring visiting-faculty doctors to use the title "visiting faculty" on their name tags; (2) posting information on the board's website describing the Visiting Faculty Certificate;<sup>252</sup> and (3) requiring visiting-faculty doctors to obtain a signed acknowledgement from patients stating that they understand that a visiting-faculty doctor is treating them.<sup>253</sup> When the public becomes more aware of visiting-faculty doctors practicing in the state, these name tags and acknowledgement forms might become unnecessary. But for now, because patients rely on the board and assume that doctors practicing in the state are fully licensed,<sup>254</sup> the board must inform patients when a visiting-faculty doctor is treating them.

#### VII. AMBIGUITIES IN THE VISITING FACULTY CERTIFICATE

Besides adding requirements to the Visiting Faculty Certificate and making it renewable, Ohio also must clarify ambiguities in that license. The Visiting Faculty Certificate does not directly require an applicant to be proficient in spoken English; rather, it "amplifies" the proficiency-in-spoken-English section.<sup>255</sup> An applicant for an Ohio medical license must demonstrate a proficiency in spoken English if the applicant's eligibility for a license is based on the foreign medical certificate and completion of the undergraduate education requirements outside the United States.<sup>256</sup>

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the meeting minutes). At this board meeting, board member Timothy Jost suggested that an applicant for the interim license must not have had a "malpractice judgment or settlement of \$25,000" be changed to allow an applicant to be eligible if he had not had a "malpractice decision in the last five years." *Id.*

<sup>251</sup>*Cf.* GROSS, *supra* note 11, at xv (stating that the "public has tolerated dependency because gaining access to the information necessary for self-determination is difficult").

<sup>252</sup>The author searched the board's website under "Consumer's Guide," "Helpful Hints for Consumers," and "Licensure Requirements" for information on the Visiting Faculty Certificate. State of Ohio Medical Board, <http://med.ohio.gov/> (last visited Feb. 9, 2006). The website has only a Visiting Faculty Certificate "application and instructions," which are not addressed to patients, do little to educate patients on that license, and takes three clicks to find. State of Ohio Medical Board, Visiting Medical Faculty Application, <http://med.ohio.gov/pdf/applications/VISITMED.PDF> (last visited Feb. 9, 2006).

<sup>253</sup>*Compare* Medical Board of California's Special Programs Task Force, *supra* note 133 (recommending similar requirements).

<sup>254</sup>GROSS, *supra* note 11, at xv (stating that the "public has tolerated dependency because gaining access to the information necessary for self-determination is difficult").

<sup>255</sup>OHIO ADMIN. CODE 4731:6-32 (2005); OHIO REV. CODE ANN. § 4731.293 (LexisNexis 2005).

<sup>256</sup>OHIO REV. CODE ANN. § 4731.142 (LexisNexis 2006). "[A]n individual must demonstrate proficiency in spoken English to receive a certificate to practice issued under section 4731.12 of the Revised Code if the individual's eligibility for the certificate is based in

To obtain a Visiting Faculty Certificate, however, an applicant does not need to meet either of those requirements.<sup>257</sup> So, it appears that this language requirement does not apply to visiting-faculty doctors. Because all languages have idiosyncrasies that can be confusing to a non-native speaker, doctors not proficient in spoken English cannot effectively communicate with patients.<sup>258</sup> To prevent visiting-faculty doctors not proficient in spoken English from frustrating patients,<sup>259</sup> Ohio must require Visiting Faculty Certificate applicants who received their licenses outside of the United States to demonstrate proficiency in spoken English.

Ohio also must clarify other ambiguities in the current Visiting Faculty Certificate. Some of those ambiguities are related to the scope of a visiting-faculty doctor's practice: (1) whether institutions and the visiting-faculty doctor may bill for services, and (2) what is encompassed by "may practice only as is *incidental* to teaching duties at the school or at the teaching hospitals affiliated with the school."<sup>260</sup> Other ambiguities in the license are related to disciplining visiting-faculty doctors, their supervisors, and the institutions at which they practice: (1) whether they are subject to cutes and fines, letters of reprimand, and revocation; (2) if they are subject to those penalties, whether they are entitled to the same due process as licensees; and (3) whether the board may deny appointments to institutions with a history of abuse and violations.<sup>261</sup> By clarifying these ambiguities, Ohio will make the Visiting Faculty Certificate less open to abuse and easier to administer.

#### VIII. OHIO PRECEDENTS FOR A RENEWABLE VISITING FACULTY CERTIFICATE

Many Ohio precedents make having a renewable Visiting Faculty Certificate reasonable. For one, the board has renewed some doctors' Visiting Faculty Certificates. Ohio has also allowed the board to fully license foreign-educated doctors without examination and has allowed the board to fully license foreign medical-school graduates, without requiring them to pass an exam. Lastly, Ohio allows foreign-educated dentists to renew their profession's version of the Visiting Faculty Certificate.

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part on certification from the educational commission for foreign medical graduates and fulfillment of the undergraduate requirements established by *section 4731.09 of the Revised Code* at an institution outside of the United States. The individual may demonstrate such proficiency by obtaining a score of forty or higher on the test of spoken English conducted by the educational testing service." *Id.* (emphasis in the statute).

<sup>257</sup>OHIO ADMIN. CODE 4731:6-32 (2005).

<sup>258</sup>E.g., the phrase "I have butterflies in my stomach" might mean, among other things, that a person literally has butterflies in his or her stomach or that a person is nervous.

<sup>259</sup>*Meeting Minutes*, July 1990, *supra* note 149, at 5150.

<sup>260</sup>OHIO ADMIN. CODE 4731:6-32 (2005); OHIO REV. CODE ANN. § 4731.293 (LexisNexis 2005) (author's emphasis).

<sup>261</sup>*Compare* Medical Board of California's Special Programs Task Force, *supra* note 133 (recommending similar requirements).

A. *De Facto Renewals of the Visiting Faculty Certificate*

The board has already renewed some doctors' Visiting Faculty Certificates.<sup>262</sup> In two instances, the board issued new Visiting Faculty Certificates immediately after the doctors' first licenses expired.<sup>263</sup> Also, the doctors' program activity for the second one-year period was the same as the first.<sup>264</sup> Because the board has issued de facto renewals of the Visiting Faculty Certificate,<sup>265</sup> Ohio should allow the board to renew all Visiting Faculty Certificates. Each doctor licensed under a Visiting Faculty Certificate should have the same opportunity to seek renewal. Without having notice, through the statute and regulations, that the board will renew Visiting Faculty Certificates, many doctors might leave, or have left, Ohio not knowing that the board will at least consider renewal. Also, without that notice, many doctors might avoid coming to Ohio after reading in the law that the Visiting Faculty Certificate is nonrenewable. Renewing only certain doctors Visiting Faculty Certificates gives the impression that some, perhaps more-connected, doctors are favored over others. To encourage doctors to come to Ohio and to be fair to all visiting-faculty doctors, Ohio must make the Visiting Faculty Certificate renewable.

B. *Ohio's Original Medical-License Statute*

Another justification for a renewable Visiting Faculty Certificate is that there is a precedent for it in Ohio medical-license law. The state has allowed foreign medical-school graduates to practice medicine, without requiring them to pass an exam.<sup>266</sup> Also, Ohio has allowed residents to practice medicine if they held a license from another state's or country's medical society.<sup>267</sup> The reasons that the legislature allowed foreign doctors to practice in the state are unknown. One could guess, however, that Ohio allowed foreign doctors to practice in the state because it was facing a concern similar to one that the state is encountering today: a need for qualified doctors.<sup>268</sup> Some might dismiss this law as outdated, but Americans in the later part of the nineteenth century just as easily could have made the same argument against reverting to another outdated licensure law: granting medical boards the authority to license doctors.<sup>269</sup>

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<sup>262</sup>Drs. Frank Klaus Wacker and Elmer Merkle both received two Visiting Faculty Certificates. *Visiting Medical Faculty Certificates Issued*, *supra* note 169. The State Medical Board's Meeting Minutes for the months before and after these doctors' first Visiting Faculty Certificates expired did not mention them. The State Medical Board of Ohio Minutes, <http://www.med.ohio.gov/2002minutes.htm> (last visited Feb. 9, 2006).

<sup>263</sup>*Id.*

<sup>264</sup>*Id.*

<sup>265</sup>*Id.*

<sup>266</sup>1868 LAWS OF OHIO 146.

<sup>267</sup>1868 LAWS OF OHIO 146.

<sup>268</sup>*See supra* Part IV.

<sup>269</sup>*See supra* Part II.A.

C. *The Limited License of Ohio's Dental Profession*<sup>270</sup>

Current Ohio law offers a more recent precedent than Ohio's original medical-license statute. Under Ohio statute, foreign dentists may receive a Limited License to practice dentistry in the state without passing an exam.<sup>271</sup> The Limited License allows a visiting-faculty dentist to practice dentistry "in connection with programs operated by the endorsing dental college."<sup>272</sup> To receive a Limited License, an applicant must have graduated from a dental college, be licensed in another state or country, and possess a full-time appointment to a dental college's faculty.<sup>273</sup> The Limited License is renewable annually and expires when the visiting-faculty dentist's full-time faculty appointment ends.<sup>274</sup>

Because of these Ohio precedents, allowing doctors who do not meet the full-licensure requirements to practice in the state is reasonable. Therefore, Ohio must make the Visiting Faculty Certificate renewable.

IX. CONCLUSION

A. *The "Terrific Idea": A Renewable Visiting Faculty Certificate*

Dr. Derek Raghavan is the kind of doctor that Ohio must retain. Dr. Raghavan has passed a clinical exam and the exam required for foreign doctors to practice in America, and he is licensed in California and New York.<sup>275</sup> Before coming to America, Dr. Raghavan headed the Royal Australian College of Physicians' Oncology Training Committee.<sup>276</sup> Dr. Raghavan also has an impressive American resume: he was Professor of Medicine and Urology at the State University of New York at Buffalo and the head of Medical Oncology and Associate Director for Clinical Research at the University of Southern California.<sup>277</sup> Dr. Raghavan has written extensively about developing anti-cancer drugs.<sup>278</sup> Since graduating from medical school in 1974, he has never received any citations or threats of litigation.<sup>279</sup>

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<sup>270</sup>Leah Pappas and Dan Reinhard, *supra* note 240.

<sup>271</sup>OHIO REV. CODE ANN. § 4715.16 (LexisNexis 2006).

<sup>272</sup>*Id.*

<sup>273</sup>*Id.*

<sup>274</sup>*Id.*

<sup>275</sup>The State Medical Board of Ohio, *Meeting Minutes*, September 8, 2004, 14419 at 14442-43 [hereinafter *Meeting Minutes*, September 2004], available at <http://www.med.ohio.gov/pdf/Minutes/09-04.pdf>.

<sup>276</sup>*Id.* at 14443.

<sup>277</sup>The State Medical Board of Ohio, *Meeting Minutes*, April 13, 2005, 14983 at 15052-53 [hereinafter *Meeting Minutes*, April 2005], available at <http://www.med.ohio.gov/pdf/Minutes/04-05.pdf>.

<sup>278</sup>*Meeting Minutes*, September 2004, *supra* note 275, at 14444.

<sup>279</sup>*Id.*

In 2003, after conducting a worldwide search, the Cleveland Clinic chose Dr. Raghavan, “one of the world’s leading oncologists,” to head its cancer center.<sup>280</sup>

After initially practicing in Ohio under a Visiting Faculty Certificate, Dr. Raghavan sought another license before it expired.<sup>281</sup> Specifically, Dr. Raghavan applied for a License by Endorsement of a License Granted by Another State, which requires that applicants pass an exam and meet educational and other requirements.<sup>282</sup> Although Dr. Raghavan met this license’s exam requirement, he had not graduated from an accredited medical school.<sup>283</sup> Therefore, to receive this license, Dr. Raghavan had to show that he had “completed not less than twenty-four months of graduate medical education through the second-year level of graduate medical education or its equivalent as determined by the board.”<sup>284</sup> At its April 14, 2004 meeting — one day before his Visiting Faculty Certificate expired<sup>285</sup> — the board finally accepted Dr. Raghavan’s *thirty years* of experience and training as equivalent to *twenty-four months* of graduate medical education through the second-year level and granted him a License by Endorsement of a License Granted by Another State.<sup>286</sup> The board, however, was willing to grant Dr. Raghavan a new license only after he hired a lawyer, drove to Columbus, and petitioned the board. After going through this ordeal to continue practicing in Ohio, will Dr. Raghavan recommend this state to his colleagues?

Did Ohio really make the one-year Visiting Faculty Certificate nonrenewable to protect patients from doctors like Dr. Raghavan who have practiced for over thirty years without receiving a citation or a threat of litigation? Perhaps, the state, under pressure from some in the medical profession, was concerned about something else: lower-cost foreign doctors undercutting health care costs. Regardless, by adding requirements to receive and maintain a Visiting Faculty Certificate, Ohio can make that license renewable and make patients safer. The new requirements will attest to visiting-faculty doctors’ competence, while not discouraging them from coming to the state. A renewable Visiting Faculty Certificate will be the “terrific idea [that] solve[s] a lot of problems, allowing Ohio to attract physicians into this State.”<sup>287</sup>

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<sup>280</sup>*Id.*

<sup>281</sup>*Id.*

<sup>282</sup>*Meeting Minutes*, April 2005, *supra* note 277; *see also* OHIO ADMIN. CODE 4731:6-16 (2005); OHIO REV. CODE ANN. § 4731.09 (LexisNexis 2005); OHIO REV. CODE ANN. § 4731.091 (LexisNexis 2005); OHIO REV. CODE ANN. § 4731.14 (LexisNexis 2005); OHIO REV. CODE ANN. § 4731.142 (LexisNexis 2005); OHIO REV. CODE ANN. § 4731.29 (LexisNexis 2005).

<sup>283</sup>*Meeting Minutes*, April 2005, *supra* note 277, at 15052 (lacking education from a Liaison Committee on Medical Education accredited medical school).

<sup>284</sup>OHIO REV. CODE ANN. § 4731.14 (LexisNexis 2005).

<sup>285</sup>*Meeting Minutes*, September 2004, *supra* note 275.

<sup>286</sup>*Meeting Minutes*, April 2005, *supra* note 277 at 15053.

<sup>287</sup>*Meeting Minutes*, October 1990, *supra* note 2.

*B. The Process of Changing the Law*

Because Ohio passed a statute making the Visiting Faculty Certificate nonrenewable and limited to one year, the legislature would have to amend that law to make the license renewable. Most likely, the legislature will act on the board's recommendation. Nothing, however, prevents other interested parties — e.g., medical schools, hospitals, doctors, medical societies, and patients — from lobbying the legislature to change this law without the board's recommendation. For example, before the legislature enacted the Visiting Faculty Certificate in 1992, the deans of Ohio's medical schools offered a competing proposal to the legislature.<sup>288</sup> Although the legislature rejected that proposal, the same result might not happen this time, as reversing the state's economic skid is now a priority.<sup>289</sup> Because the board seems unresponsive to Case's concerns — and might be considering further restricting or abolishing the Visiting Faculty Certificate<sup>290</sup> — interested parties will probably have to lobby the legislature to (1) make the Visiting Faculty Certificate renewable; (2) allow visiting-faculty doctors to practice at rural hospitals after practicing under their Visiting Faculty Certificates; (3) clarify ambiguities in the Visiting Faculty Certificate; (4) require an applicant to meet additional requirements to receive a Visiting Faculty Certificate; (5) require an applicant to meet additional requirements to maintain an amended, renewable Visiting Faculty Certificate; and (6) notify patients when a visiting-faculty doctor is treating them. By making these changes Ohio will become more competitive in recruiting highly-sought-after foreign research doctors to the state and make patients safer.

## X. EPILOGUE

On November 9, 2005, a lawyer representing Case Western Reserve University (Case) asked the board's Legislative Committee to allow visiting-faculty doctors to practice in the state until their faculty appointments end and in areas "as otherwise approved by the board."<sup>291</sup> The lawyer told the committee that because of the Visiting Faculty Certificate's one-year limit and nonrenewability, Case has trouble "recruiting and retaining world-class physician researchers."<sup>292</sup> He added that the license's restrictions are causing "Ohio [to] los[e] qualified physicians and researchers to other institutions such as Duke University."<sup>293</sup> Committee and board member Dr. Andrew Robbins, Jr. "questioned the reason an eminent physician would not be able to obtain a license to practice" in Ohio and stated that "eminent physician/researchers should be able to obtain a medical license in Ohio; they have a full year to get the license."<sup>294</sup> Dr. Robbins' concern shows the board's and the

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<sup>288</sup>*Id.*

<sup>289</sup>*See supra* Part IV.C.

<sup>290</sup>*See infra* Part X.

<sup>291</sup>The State Medical Board of Ohio's Licensure Committee, *Meeting Minutes*, November 9, 2005 [hereafter Licensure Committee] (on file with author).

<sup>292</sup>*Id.*

<sup>293</sup>*Id.*

<sup>294</sup>*Id.* at 6-7.

committee's ignorance as to what kind of doctors visiting-faculty doctors are and why they may not practice in the state. For instance, after practicing for the many years he has practiced, would Dr. Robbins be able to pass the board's exam now? If he was a visiting-faculty doctor with his vast experience, would Dr. Robbins want to waste his time studying for an exam when he is supposed to be conducting important medical research? Or, would Dr. Robbins want to stop practicing for at least nine months so that he could complete a residency or internship? Contrary to Dr. Robbins' belief, doctors can be eminent, or just competent, without meeting Ohio's restrictive licensure requirements.<sup>295</sup>

The committee then discussed the scope of the visiting-faculty doctor's practice.<sup>296</sup> Committee and board member Dr. Patricia Davidson suggested that an amended Visiting Faculty Certificate allow visiting-faculty doctors to conduct their research, but prohibit them from practicing medicine.<sup>297</sup> Dr. Robbins responded that doing so would be difficult because visiting-faculty doctors need to perform clinical care of patients to conduct their research.<sup>298</sup> Dr. Robbins is correct that restricting the Visiting Faculty Certificate as Dr. Davidson suggested would prevent visiting-faculty doctors from conducting their research and, thus, eliminate the reason for having that license. Committee and board member Dr. Nandlal Varyani then suggested that an amended Visiting Faculty Certificate should expire once the visiting-faculty doctors complete their research.<sup>299</sup> The kind of license that Dr. Varyani described is not competitive with other states<sup>300</sup> and unfairly burdens visiting-faculty doctors. For example, would Dr. Varyani want to transplant his family for a few years so that he can complete his research and then have to move because he can no longer practice in the state? Or, if Dr. Varyani was capable of getting another research project, which might require him to apply for and receive a federal grant, what would he do between research projects? Dr. Varyani's suggestion also is short-sighted because the idea is to keep visiting-faculty doctors practicing and researching in the state as long as possible, so that Ohio can reap the benefits of their presence in the state.<sup>301</sup> The committee ended its discussion by asking Case to submit more information on the "practice duty" of visiting-faculty doctors.

When the board discussed the committee meeting at its November 10, 2005 meeting, it was less receptive than the committee to Case's concerns.<sup>302</sup> Dr. Robbins stated that doctors who want to practice in Ohio for more than one year should get

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<sup>295</sup>See *supra* Part II.F.

<sup>296</sup>Licensure Committee, *supra* note 291.

<sup>297</sup>*Id.*

<sup>298</sup>*Id.* Dr. Robbins' response seems to contradict an earlier statement that he made in the same meeting: "if the physicians and researchers are only conducting research, they would not need a license [to practice medicine] and perhaps the visiting faculty certificates could be renewed on a yearly basis subject to board approval." *Id.*

<sup>299</sup>*Id.*

<sup>300</sup>See *supra* Part V.

<sup>301</sup>See *supra* Part IV.

<sup>302</sup>*Meeting Minutes*, November 2005, *supra* note 134.



full licenses.<sup>303</sup> Board member Dr. Anita Steinbergh added that doctors “shouldn’t be doing patient care if they don’t meet licensure requirements.”<sup>304</sup> So, instead of making the Visiting Faculty Certificate renewable, it seems that the board is interested in further restricting or, perhaps, abolishing it. Doing either of those things would stymie Ohio’s effort to assert itself in the “knowledge economy.”<sup>305</sup> By abolishing, further restricting, or maintaining the current Visiting Faculty Certificate, the board will remain out of step with Ohio voters, who set high-tech research as a priority by passing the \$2 billion economic-development initiative in November 2005.<sup>306</sup> That result would be unfortunate for a state that is attempting to rebound economically.

AUSTIN MCGUAN<sup>307</sup>

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<sup>303</sup> *Id.*

<sup>304</sup> *Id.*

<sup>305</sup> *See supra* Part I.

<sup>306</sup> Gaylord, *supra* note 193.

<sup>307</sup> This note is dedicated to my parents, Sean and Patricia McGuan, who stimulated my interest in issues like the one discussed in this paper; my grandmother Catherine McGuan, whose academic accomplishments set a high standard for us all; and my grandfather Fred Tyler, whose companionship sustained me through law school.