Question text	Answers provided by Shirley Svorny
I'll look forward to your discussion. At face value this seems to be more semantics than anything else. A rose by any other name is still a rose. Given your standings and reputation though, I will give you the benefit of the doubt!	The difference is that there could be new categories of clinicians.
How to determine which organizations can certify medical professionals? For example, many physicians have foregone board recertification by an "American Board of ..." due to onerous recertification requirements. Some have opted for NBPAS certification instead.	For academic degrees/credentials states could piggyback on the efforts of the US Dept or Education and the Council for Higher Education Accreditation. Both recognize accrediting organizations which, in turn, accredit credential and degree programs. The National Commission for Certifying Agencies (NCCA) offers the same type of recognition for organizations that accredit non-academic programs.
Why would your system produce better results than the current accreditation system produces for colleges?	Our system would allow the development and credentialing of new categories of clinicians. In terms of the results, oversight occurs at the point of care.
How would you prevent professions with newly expanded scopes of practice from step laddering-i.e., join with previous adversaries to prevent future new entrants- as osteopaths now join with MD's to prevent NP's from expanding their SOP's?	There would always be the potential for new programs to credential individuals with scopes of practice that meet the needs of employers.
What considerations should states make for licensing immigrants?	To the extent the training of immigrant clinicians is not recognized by the states, our proposal would facilitate access to the healthcare workforce for these individuals. Under our plan, new programs could be set up to certify foreign-trained clinicians. The programs would decide on entry requirements, the scope of practice associated with the credential, and the method(s) of assessing relevant knowledge and skills.
At CHPgh (PA), onc or heme nurse pract. perform bone marrow bx. Usually MD in the room in order for the MD to bill.	Interesting. At City of Hope in Duarte (Los Angeles) I don't think a doctor was in the room. At Kaiser the procedure is performed by physicians. One NP I met at COH learned the skill at Children's Hospital Los Angeles.
Are panelists familiar with the Goldwater Inst/1889 Inst publication: "A Win-Win for Consumers and Professionals Alike: An Alternative to Occupational Licensing?" I've advocated private certification for some time. Legislators object to it over health care. How do we overcome their fear?	I had seen your earlier work (2014, 2017). It was my impression, at that time, that provisions of your model legislation would have allowed medical professional licensing to persist. As to overcoming fears, education might help reduce fear. But in California the fear is of offending the politically powerful California Medical Association, not a fear of patients being harmed.

3rd parties can become powerful, corrupt, inefficient, drift from their mission, subject to political pressure and cronyism. Such criticisms have been leveled at existing third-party accreditors, like the Amer Bd of Int Med, the Acred Coun for CME, The Joint Commission. How will this be prevented?	It won't be prevented, but there will be other options for certification. For example, Kaiser Permanente could set up programs to train/credential individuals in areas where they see a value in contributing to the health team.
Isn't third party certification the same thing only different from what we have now?	You are right, we do have a lot of third-party certification in health care. This would build on that, allowing for new categories of clinicians.
How will the public be protected? State licensing boards provide public protection and ensuring safe providers. They create the environment to allow individuals who have been harmed to seek justice.	We don't agree that state boards protect the public. Protection occurs at the point of care, motivated by liability and other factors. As now, harmed individuals could sue clinicians.
How would newly graduated professionals like doctors or lawyers be admitted to the general profession medicine or law?	Just as they are now. The Liaison Committee on Medical Education (LCME), which accredits medical school programs, is officially recognized by the U.S. Department of Education to accredit medical schools in the United States. New programs might arise to train health care clinicians to take on tasks that physicians perform, programs that do not fit the LCME mold.
What might be the implications for and injured patient seeking legal remedy, for harm, in this model?	Harmed individuals could sue clinicians. This would not change.
Who watches the watchmen? Why won't cert awarding groups be the new licensing board and have same fairness issues?	Because other certificate awarding groups can enter. Employers will show a preference for those credentials.
Payers already dictate treatment so are they in essence cert awarding already? Should we shift to safety and outcomes rather than certs/licenses?	They do not determine the scope of practice of individual clinicians. That is restricted by the current licensing system. We agree that safety and outcomes are important. State licensing doesn't assure that, oversight occurs at the point of care. Credentialing and other forms of oversight on the part of (1) hospitals, (2) insurance companies setting up panels or networks, and (3) medical professional liability insurance companies protect patients.
Do hospitals do their own de facto "on the job" accrediting by reviewing how the doctor performs on the job and to only allow them to take on greater responsibilities if they excel? Does insurance encourage this oversight?	Yes they do. And medical professional liability insurance does encourage this oversight. You have it exactly right.

Certifying licensed professionals in a similar way to the way we certify educational institutions is an interesting idea. Do we have a practical example of the way that this might work? I do not see how board certification is a plausible example; it measures the additional marginal post-MD gains.	The credentials we imagine would certify either initial or incremental (marginal) skills (scopes of practice). These credentials could be stacked to establish an individual's legal scope of practice. But a legal scope of practice and what an individual may do are two different things. Oversight at the point of care determines the latter. It is already the case that credential programs for healthcare professionals are accredited in the manner to which you refer.
Medics and corpsmen treat battlefield wounds and medical conditions that afflict soldiers and civilians in the field. Would their education, training, and experience be sufficient for certification? If so, for what fields? Should DOD be an authorized certification agency?	In our system, a credential program would determine the entry requirements for the program and also the way in which the skills/knowledge would be assessed. A new certificate program could be established to facilitate the progress of medics and corpsmen into the civilian healthcare workforce. DOD could be an authorized certification agency if it were to get its program accredited by the NCCA.
The real purpose of a license is to have a credential that can be removed if a practitioner acts inappropriately. How does your proposal allow for a legally supportable removal of an incompetent practitioner from practice?	It's funny you mention that, as in the late 1970s I found other theories of licensure lacking (certification would have served to meet those purposes without restricting entry) and I proposed a theory that supported licensure over certification: the penalty of losing one's license served the purpose of discouraging physician malfeasance. The same argument had been made for licensing taxi drivers (Gallick and Sisk) and was built off a model of incentives in the labor force proposed by Ed Lazear. The premium stream (higher lifetime earnings) associated with limiting entry creates a huge penalty for malfeasance, IF it results in the loss of one's license. What has turned me away from that? The fact it is not used; states rarely remove an incompetent practitioner from practice. And learning about oversight at the point of care. And seeing how the state apparatus is manipulated by special interests.
We have a huge and growing demand for caregivers for the elderly and disabled. Yet, recruitment and retention of caregivers is very difficult. Do nursing practice agreements, get in the way of caregivers getting the opportunity to gain skills, earn more, and be a recognized part of a care team?	That is exactly the type of situation where credentialing could help. Programs would determine the entry requirements, training/skills, and the scope of practice for newly credentialed individuals.
Sounds like you are advocating the end to independent private practice when you state people should not practice outside of large organizations	This came up in the context of a discussion of the protections for patients. It is riskier to seek care from clinicians who have no affiliation at all (no hospital privileges, not in any insurance networks, no medical malpractice insurance). The National Practitioner Data Bank has relevant information, but it is not open to patients; many people think it should be.

Even if 3rd party orgs certified clinicians, & educational institutions defined & expanded scope of practices for clinicians, how do you solve reimbursement issues for expanded services, and break down institutional barriers (hospitals) that limit clinicians from practicing to the top of scope?	As capitation expands (Kaiser is growing; California uses capitation for about 80% of its Medi-Cal beneficiaries) and as Medicare moves away from fee-for-service and toward bundled payments and value-based payment, this should not be a problem. It will also solve the issues related to fee-for-service payments identified by Silver and Hyman in their book about Medicare, *Overcharged*. The barriers to practicing to the top of scope are state laws. If a hospital does not permit a clinician to practice to the top of scope, as I understand it, it must be because it has assessed the clinician's skills and found them lacking.
What role do insurers play here? As I see it, insurer liability plays a role in addition to 3rd-Party organizations and alleviates Dr. Sage's concerns about "lowest common denominator".	I agree. As to the lowest common denominator, the value of a credential is determined by employers. There is no value to a weak credential. And even the credential won't be the final word on a clinician's knowledge and skills -- they will be assessed at the point of care.
What are the greatest risks in third-party certification?	We already have third-party certification in health care. It is widespread. This would add to that. None of us could think of a risk, give us a suggestion?
How can third parties provide mechanisms to control price gouging on licensing from insurance provider oligopolies?	I don't understand this question. Licensing would be replaced by certification.
The federal and state governments have eased the rules governing telemedicine. Should the current exceptions be made permanent? Is telemedicine a development whose time has come?	Yes! Most of the post-COVID discussion of telemedicine has failed to address the barriers to interstate practice. Congress could pass a law that sets the location of the practice of medicine as that of the physician. That would facilitate interstate practice. Huge win for patients. https://www.cato.org/sites/cato.org/files/2020-09/regulation-v43n3-6-updated.pdf#page-5
Can you address the problem of a "Gresham's Law" of credentials that your proposal might cause? For instance, if nurse practitioners could do colonoscopies, wouldn't that make it silly for people to go through the much more extensive & expensive training to become a gastroenterologist?	You are right, in most situations, gastroenterologists would no longer perform colonoscopies. That is the whole point. Gastroenterologists would have a more sophisticated set of practice areas.
To what degree do you think interstate compacts like the Nurse Licensure Compact relieve some of the issues you are raising?	The NLC offers license portability across states, it is not about scope of practice -- it does not address any of the same issues. [Note that the Interstate Medical Licensure Compact does not offer license portability.] Our plan is not one in response to a shortage of physicians (for a variety of reasons, I think the AAMC estimates of an impending physician shortage are wrong); right-skilling makes sense in terms of cost, access to the professions, and access to care.

What do you say to those who are suspicious that decentralized certification is just another means to privatize an already dysfunctional healthcare system?	We already have third-party certification in health care. It is widespread. This would add to that. The provision of care is already privatized, provided by private organizations.
Shirley, Tony buys strawberries from the side of the road.	Yes and, having talked with Tony, I understand there are various levels of oversight that assure him of the quality of the product!
Are Hospitalists making an intrusion?	Into healthcare? Yes. Many physicians trained in primary care (and other fields) choose to work as hospitalists. But you probably know this. I'm not sure what you mean.
Downside is new process same outcome...or change for change's sake. Perhaps new players with equal or more power and again monopolistic practices	We certainly don't want change for change's sake. New players, yes. Monopolistic practices are harder to maintain if there is entry. Historically, physician groups have successfully restricted competition via the state licensing apparatus. This would allow new credentials in practice areas that have been in their domain (examples include colonoscopy, cataract surgery).