Because professional licensing boards represent nondemocratic elements in a political system founded on democratic principles, their legitimacy has been questioned in recent years. This article examines legal and medical licensing boards in three states—Georgia, California, and Massachusetts—to determine whether developments in those states suggest a trend toward appointing citizen members to boards. The article concludes that although public acceptance of licensing boards might improve in the wake of appointing citizen members, such a cosmetic change does not necessarily ensure that the "public interest" is protected. Only when the private interests of democratically selected citizen board members are balanced against the private interests of professional board members will concerns about the legitimacy of licensing boards possibly be assuaged.

PRIVATIZING PROFESSIONAL LICENSING BOARDS Self-Governance or Self-Interest?

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The aftermath of the 1994 congressional elections has certainly not been nearly as revolutionary as Newt Gingrich so boldly prophesied in the *Contract With America* (Gillespie & Schellhas, 1994). It is probably more accurate to say that the changes to date—a balanced budget (reversing three decades of deficit spending), welfare reform, tax cuts for families,

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the short-lived line-item veto—have been incremental reforms. From a political perspective, though, the ideas animating these and other changes are potentially of far greater significance than what may or may not become law in the near future. Indeed, if the commentators and pollsters have gauged it correctly, the nation is witnessing a number of interrelated debates about the proper form of its government, the extent to which governmental powers should be decentralized, and the kinds of citizens (or noncitizens) that the democratic republic should encourage or discourage. These issues are hardly simple ones amenable to a little procedural tinkering here and there. Decisions to implement some reforms rather than others will have potentially profound long-term consequences for the regime. But because these changes are almost always advanced under the banner of democracy, they have helped to rekindle the protracted debate about the proper limitations on government in our regime and, more particularly, about the appropriate place within it of various nondemocratic elements.

Whether one terms it *empowerment*, *decentralization*, or *devolution*, the fundamental political problem for many of the nondemocratic elements of our regime concerns their legitimacy. Stated more generally, the nondemocratic elements—which include bureaucracies, the largest part of most levels of government—are currently struggling to fashion an appropriate answer to what Herbert Storing once characterized as the great "Who says?" question. Who says I have to defer to you? In a democracy founded on the principle of "All men are created equal," it is the critical question that the ordinary citizen considers (and nowadays frequently asks) when confronted by those claiming to wield "official" political power.[1] The most confident responses echo from the governors, legislators, mayors, and other assorted officials who are directly elected by the citizenry. If the citizens dislike the "You did!" retort, they readily understand that these officials serve finite terms and can be stripped of their powers at the next election. This principal corrective to abuses of power was considered elementary by the Founders. In an era that was dominated by hereditary monarchs claiming to have been given lifetime tenure by divine right, they fully understood that the proper securing of citizens' rights was wholly dependent on governments, and that the best of these derived "their just powers from the consent of the governed" (Declaration of Independence, as cited in Rubin & Rubin, 1992, p. 83).

But what about those far more numerous nonelected individuals who wield various degrees of political power over the citizens?[2] With increasing frequency, some of their responses to the challenge of "Who says?" have been the equivalent of a Gallic shrug followed by a tentative one-

armed embrace of the citizenry. Following the "empowerment" model popularized by Osborne and Gaebler (1992, esp. pp. 49-75) and the National Performance Review's well-publicized report on improving government accountability by making it more responsive to customers (Gore, 1993), some unelected entities at the state and local levels have been experimenting with ways to bolster their legitimacy by reaching out directly to the ultimate source of "just powers," the citizens themselves. In certain cases, the outreach occurs because an entity's answer to the "Who says?" query is so muddled or unconvincing that forces marshaling under the flag of "privatization" seek to return its functions and political powers directly to the people. Nowhere is this situation more starkly illustrated than in the matter of professional licensing boards, those nonelected, state-sanctioned entities that are given the near exclusive political power to define, to nurture, and to control not only *how* millions of citizens pursue their chosen livelihoods but even *if* they will be permitted to do so.

From a theoretical perspective, professional licensing boards are especially difficult to justify in a regime that is both democratic and infused with Lockean principles (W. D. Richardson, 1997, pp. 19-26). The most common explanation for requiring licenses involves a concern for the public interest, by which is generally meant a desire to protect the citizens from unknowingly putting their lives, liberty, or property at risk. Because the level of knowledge required to assess the qualifications of, say, a lawyer or a physician is so great, the average citizen is incapable of properly understanding their answers to that most critical of Socratic questions, namely, "What do you know?" Therefore, the state delegates political power to boards composed of intelligent professionals who *are* capable of assessing the answers. If board members are satisfied, the positive side is that they then issue state "licenses" that practitioners can readily display to the citizenry as visible proof that they do indeed "know" their field. If the board members are dissatisfied, however, the negative side is that the power of the state is used to bar an individual from practicing a given profession within that political jurisdiction.

As is so frequently the case in these situations, an idea that seems rational and defensible in theory quickly attracts legions of opponents when it is put into practice. Professional licensing boards established to protect the public interest have had ample time to reveal their operational weaknesses. Among their harshest and most influential critics has been Milton Friedman, the 1976 Nobel Laureate in Economics. As a forceful proponent of the benefits of free market policies, Friedman is a progenitor of the contemporary privatization movement that is still gathering

momentum throughout the nation. His hostility to licensing takes two forms that are relevant to the present study. First, he sees the state's decision to give its imprimatur to certain individuals but not to others as the worst form of paternalism. The democratic citizens who would be the consumers of these professional services are being told that they are incapable of making rational choices and so the state will do so for them (Friedman, 1962, p. 148). In addition to limiting the scope of available choices, state licensing also encourages irresponsibility by removing incentives for citizens to assume the consequences for the limited choices they are able to make. Thus, rather than thoroughly inquiring into the educational and experiential backgrounds of licensees, citizens are encouraged to expect that the licenses are an appropriate substitute for their own efforts.

The second problem with licensure is that the boards almost invariably become captured by those with the greatest interest in limiting access to the regulated professions. In the language of the economist, the producer-professionals making their livelihoods in a given occupation are much more likely to be politically well organized and adept at advancing their collective self-interest than are the consumer-citizens who are the infrequent users of their services. Friedman, who abhors monopolistic concentrations of power, minces no words here. He considers professional licensing boards to be the contemporary equivalents of "medieval guilds." "In practice, the considerations taken into account in determining who shall get a license often involve matters that, so far as a layman can see, have no relation whatsoever to professional competence" (Friedman, 1962, p. 141).

Although he can see almost no circumstances where licensing would be an acceptable option in a democratic regime, Friedman does concede that requiring those who want to practice a given profession to register with the state might sometimes be appropriate. This approach provides the maximum level of entry into a profession, the greatest range of choice to the citizens, as well as some protection against incompetence. (The latter protections, though, are essentially of the "here's-the-identity-of-the-perpetrator" variety so that an aggrieved consumer-citizen can pursue redress through the legal system.) From Friedman's perspective, however, the initiation of registration all too frequently begins the process of setting the self-interested producer-professionals on the path to the guild system. After registration comes the organized political push for state certification of the profession. Once that is achieved, the logical next step is to close the profession to any but licensed practitioners (Friedman, 1962, p. 148). The persistence of this pattern obviously helps to persuade Friedman that, with

only a few possible exceptions, the ideal solution to the regulation of the professions should be to remove all restrictions "except for legal and financial responsibility for any harm done to others through fraud and negligence" (Friedman, 1962, p. 158).

As the 40th anniversary of Friedman's indictment of professional licensing boards looms on the horizon, it seems appropriate to examine the status of such boards and the extent to which they are adapting to some of the ideas he advocated. In February 1997, Georgia's newly elected secretary of state proposed to deregulate all 35 licensing boards falling under his jurisdiction.[3] This announcement proved to be the catalyst for the present study. After careful consideration, the authors decided to examine professional boards in three major states: Georgia, owing to the secretary of state's announcement as well as to two of the authors' institutional affiliations; and two bellwether jurisdictions, California and Massachusetts. In addition to representing three different regions, these states have responded to concerns about the legitimacy of professional boards in different ways. Because the legal and medical professions were clearly the most sophisticated in their organization and, in Friedman's terms, constituted the kind of concentrated political/economic power that was likely to be a target for reform efforts, the authors chose to focus on them.

THE LEGAL PROFESSION

As the legal profession developed in the United States, lawyers came to view themselves as members of a special, privileged professional class—guardians of the individual rights of the regime. According to Geoffrey C. Hazard, Jr., a University of Pennsylvania law professor and a renowned authority on ethics and the legal profession, lawyers assumed an important role in "counterbalancing the vagaries of popular government with the pressures of the market." By protecting business interests through the use of both substantive and procedural rules, lawyers assumed an important role as "mitigators of the destructive tendencies of democracy" within a political system "committed both to popular government and constitutional constraints on government" (Hazard, 1991, p. 1241).

Owing to the legal profession's supposedly unique role within a democratic regime, lawyers have always insisted that nonlawyers could not understand, and therefore could not effectively regulate, the profession (Lumbard, 1981; Wilkins, 1992; Wolfram, 1978). As the modern bar

developed in the 19th and 20th centuries, lawyers were more or less self-policing. Canons of ethics were promulgated based on the simple presupposition "that right-thinking lawyers knew the proper thing to do and that most lawyers were right-thinking" (Hazard, 1991, p. 1250).

Beginning in the latter half of the 20th century, however, a demand for greater citizen control over lawyers was made because of several factors: the perceived "litigation explosion"; a new concern for equal access to the judicial system for women and ethnic minorities; increased industrialization and urbanization, which led to increasingly complex conflicts and injuries as technology became more advanced; newly recognized "rights"; and the understanding that lawyers were not above "great temptations to shoulder aside one's competitors . . . cut corners . . . [and] ignore the interests of others in the struggle to succeed" (Bok, 1983, p. 575; see also Morgan, 1977).

As the legalization of the bar has evolved, the question has arisen: What role, if any, should the public exercise in overseeing lawyer discipline (Torry, 1997)? The answer varies among states and, judging by the literature, is far from uncontested or uniform. An examination of American Bar Association reports and committee activities as well as the disciplinary systems in Georgia, California, and Massachusetts reveals substantial differences in the roles citizens are permitted to play in disciplining practitioners.

THE AMERICAN BAR ASSOCIATION

The American Bar Association (ABA), a 385,000-member professional association that represents about one third of the nation's practicing attorneys, lists as one of its principal purposes "the maintenance of the highest professional standards, the advancement of the administration of justice and service to the legal profession" (ABA, 1987). To achieve that goal, the ABA has long promoted codes of legal ethics and model disciplinary rules. Indeed, the first ethical canons were adopted by the ABA on August 27, 1908. Eventually, the canons were changed to a series of disciplinary rules with the adoption of the Code of Professional Responsibility in 1970. The 1983 Model Rules of Professional Responsibility further codified the ethical standards of the legal profession (ABA, 1983).[4]

The organization's efforts to develop standards of professional conduct and disciplinary guidance have not stopped with promulgation of the Model Rules. Since 1968, the ABA also has maintained a database of all

public disciplinary actions taken against lawyers, which is available to the public for a fee. Unfortunately, the database is not always complete or up-to-date because each state bar association or disciplinary commission must report information for inclusion, and this does not always happen in a timely manner. Nonetheless, the ABA attempts to provide current, accurate information by issuing universal identification numbers to attorneys so the database can track misconduct in the event that an attorney moves to another state (ABA, 1995b, p. 2).

ABA commissions and committees have been active in pushing ethical and disciplinary issues onto the national agenda as well. In February 1967, the Special Committee on Disciplinary Enforcement, chaired by former United States Supreme Court Justice Tom Clark, was created by the ABA and charged with an important mission:

> to assemble and study information relevant to all aspects of professional discipline, including the effectiveness of present enforcement procedures and practices and to make such recommendations as the Committee may deem necessary and appropriate to achieve the highest possible standards of professional conduct and responsibility. (ABA, 1970, Preface, p. 1)

Three years later, the committee produced a seminal report for the ABA, *Problems and Recommendations in Disciplinary Enforcement*, which called the state of lawyer disciplinary systems a "scandalous situation." The Clark Report, as it came to be called, specified more than 30 areas in need of reform and suggested model structures and programs for effecting change. Recognizing that implementation at state and local levels would be difficult, the report nonetheless provided recommendations on an "ideal" disciplinary structure: "The structure [should] be centralized by vesting exclusive disciplinary jurisdiction in the state's highest court under a procedure promulgated and supervised by the court in the exercise of its inherent power to supervise the bar" (ABA, 1970, Preface, p. 2). Citizen participation in, or regulation of, lawyer discipline was not recommended.

The Clark Report engendered much discussion about deficiencies in lawyer discipline, but it was the Commission on Evaluation of Disciplinary Enforcement, or the McKay Commission, that focused attention on problems of attorney discipline in the 1990s. In its 1992 report, *Lawyer Regulation for a New Century*, the McKay Commission called for a broader approach to discipline than the measures recommended in the Clark Report.[5] Specifically, the commission recommended "opening

disciplinary proceedings to the public; [n]on-lawyer involvement in disciplinary boards and panels; client protection initiatives, like protection funds, random trust account audits and record keeping verification; mandatory arbitration of fees; mediation; lawyer practice assistance; and lawyer substance-abuse counseling" (ABA, 1992, p. 1).[6]

To augment the work of the association's special committees, in 1978 the ABA established a permanent Center for Professional Responsibility to provide "national leadership and vision in developing and interpreting standards and scholarly resources in legal ethics, professional regulation, professionalism and client protection mechanisms." Since 1973, the ABA Standing Committee on Professional Discipline has assisted the judiciary and the bar in developing, coordinating, and strengthening disciplinary enforcement across the country. For instance, in 1984, the Standing Committee on the Unauthorized Practice of Law and the Standing Committee on Clients' Security Fund were merged to form the Standing Committee on Lawyers' Responsibility for Client Protection. The purpose of the new committee was to "promote reimbursement of financial losses caused by lawyer misappropriation of client funds through the establishment of funds for client protection" (ABA Home Page, 1997).

In a July 1997 press release, the ABA underscored the importance of ethical and disciplinary issues by announcing the creation of a 10-member Special Committee on the Evaluation of the Rules of Professional Conduct to examine the 1983 Model Rules of Professional Conduct and recommend changes. Delaware Supreme Court Chief Justice E. Norman Veasey was selected as the chair for the new committee, which was also known as Ethics 2000. In announcing the creation of the Ethics 2000 initiative, ABA President N. Lee Cooper said,

> We believe this examination is necessary in light of changes in the legal profession, such as the increased size and mobility of law firms, the proliferation of in-house counsel, the increase in specialization, and the impact of global communications technology on the legal community. (ABA, 1997, p. 1; Hansen, 1998, p. 100)

Many states have followed the ABA's lead in addressing concerns over lawyer disciplinary systems in their respective jurisdictions. The trend seems to be toward allowing for greater public participation in decision making, regardless of the enforcement system in place. The approaches adopted in Georgia, California, and Massachusetts provide a useful overview of what is occurring in states nationwide.

GEORGIA

By early 1997, more than 28,000 lawyers were licensed to practice law in Georgia, and the number was increasing by about 1,000 a year (Benham, 1997, p. 46). Prior to 1964, when the bar took responsibility for policing lawyers in the state, local prosecutors and courts handled cases against lawyers, although few complaints apart from outright fraud resulted in disciplinary action. In ensuing years, as the presence of the state bar grew in number and visibility, the public quest for greater control over lawyer professionalism and discipline increased as well. In response, the bar created a Consumer Assistance Program in 1995 to handle client complaints that do not involve violations of bar rules (Walston & Rankin, 1997, p. G4).

In March of that year, recognizing the need for restoring public confidence in the legal profession in the wake of the publication of the McKay Report, the Georgia Supreme Court created a 13-member panel of lawyers and nonlawyers called the Commission on Evaluation of Disciplinary Enforcement, a group chaired by Emory University School of Law Associate Dean A. James Elliott and charged with studying lawyer discipline and making recommendations.[7]

At the court's direction, the Elliott Commission studied possible changes in attorney discipline for 18 months. In September 1996, the commission made a series of recommendations to the Supreme Court in the form of a majority and minority report. The most extensive majority recommendation called for the court to create a disciplinary commission separate and apart from the bar, composed of lawyers and nonlawyers, to oversee lawyer discipline in Georgia. The Supreme Court referred the recommendations to an internal committee for review (Ringel & Heller, 1997a, p. 1).

On June 13, 1997, Georgia Supreme Court Justice Robert Benham announced the court's decision on whether to adopt all or part of the Elliott Commission's recommendations during his State of the Judiciary Address at the Georgia Bar Association's annual meeting in Hilton Head, South Carolina. Recognizing that some parties would be dissatisfied, Chief Justice Benham explained that the Supreme Court did not embrace all of the Elliott Commission's recommendations because, "[t]his radical change would involve totally restructuring the entire disciplinary structure." Owing to the lack of data from other states on the merit of such changes as well as the already stringent bar admission and readmission requirements in Georgia, the court concluded that the commission's recommendations were too far-reaching. "We believe the present

disciplinary rules, as amended, will protect the public, improve the delivery of legal services and require lawyers to act in an ethical and professional manner," the chief justice said (Benham, 1997, p. 47).[8]

Not surprisingly, Justice Benham's remarks received mixed reviews. Elliott Commission panelist Claude Sitton, a Pulitzer Prize–winning journalist and longtime critic of the Georgia State Bar, was blunt in his criticism. "This was a case of privilege vs. the people," he said. "And the people lost" (Ringel & Heller, 1997b, p. 12). Commission chair A. James Elliott was more circumspect. Although he agreed that the Supreme Court's changes were "a step in the right direction," he added that "there's a lot more that needs to be done" or "the public won't trust the system" (Ringel & Heller, 1997b, p. 1). Savannah businesswoman Jan Kahn, also a member of the Elliott Commission, told a reporter for the *Fulton County Daily Report* that she was "furious" at the court's decision to allow the bar to continue disciplining its members. "You know the State Bar is going to say, 'Leave it with the State Bar' " (Ringel & Heller, 1997b, p. 12).

Not everyone who served on the Elliott Commission was disappointed with the Supreme Court's decision. Former Supreme Court Justice Hardy Gregory, Jr., a dissenter, concluded that the court was "very wise" to leave attorney discipline with the bar. "It seems to me it would be a mistake to relieve lawyers of the responsibility to discipline themselves," he said (Ringel & Heller, 1997b, p. 12). Outgoing bar president Benjamin F. Easterlin IV likened the majority of the Elliott Commission to "a person given a credit card for the first time. They used it to buy whatever they needed but didn't stop at that point. They really went too far" (Walston & Rankin, 1997, p. G4). Incoming bar president Linda A. Klein, who opposed the Elliott Commission's most radical recommendations, said in a speech to the board of governors on June 14, 1997,

> Georgia lawyers recognize that we must police our profession to remove bad players. . . . It is in our professional self-interest to sanction those who violate the disciplinary standards. It protects the reputation of the profession and the value of a law degree. (Klein, 1997, p. 48)

CALIFORNIA

As in Georgia, the State Bar of California is an integrated, or mandatory, bar association, which means that all attorneys must be members if they wish to practice law in the state (State Bar of California, 1996). Established in 1927, the State Bar of California had 121,960 members as of April 1, 1997, making it by far the largest active bar association in the

United States. Governed by a 23-member board of governors, including a president elected by the board, the State Bar of California exercises authority over seven primary functions: (a) admissions to the profession within the state, (b) administration of justice, (c) attorney discipline, (d) legal education and professional competence, (e) bar relations and professional education, (f) public relations and publications, and (g) legal services (State Bar of California, 1996, p. 1). Public members were added to the board of governors by California Governor Jerry Brown in 1979 (Wied, 1996, p. 13).

In 1995, California attorneys came face-to-face with a proposal to remove attorney discipline from the bar when a plebiscite, SB 60, was introduced to dismantle the mandatory organization. For many California lawyers, the measure represented a significant threat to the profession because, if passed, it would have moved important functions such as admissions and discipline to a newly created Department of Consumer Affairs within the executive branch of state government. Writing in the *California Bar Journal* in May 1996, a San Diego attorney, Colin Wied, expressed mixed feelings about the condition of the bar but "regretfully" urged his colleagues to retain the mandatory organization because he could not "imagine an independent judiciary without an independent bar" and "an independent judiciary is the cornerstone of our democracy." Instead of viewing the bar as a group of unaccountable, insulated elites, Wied concluded that the attack on the California Bar Association represented an attack on the judicial branch, ostensibly in favor of the public interest, by allowing public members serving on the board of governors to place their loyalty to the authority who appointed them above the interests of lawyers and their clients. In other words, the public interest was not served. One private interest was merely substituted for another private interest (Wied, 1996, p. 13).

Although SB 60 eventually was defeated in June 1996, the state bar faced other attacks. The California legislature, for example, amended the state's Business & Professions Code, Section 6086.11, to create a Discipline Audit Panel (DAP) to replace the Complainants' Grievance Panel, effective January 1, 1996 (California Business & Professions Code, 1996). Consisting of seven voluntary members (three lawyers appointed by the board of governors and four members of the public appointed by various state officials, including the governor), the DAP was vested with broad authority to conduct "comprehensive audits of the discipline enforcement system of the State of California." To fulfill its statutory

mandate, the DAP was directed to conduct one random annual audit of closed disciplinary complaints as well as targeted audits of subject matters selected by DAP members. A staff consisting of a director, three attorneys, one legal secretary, and two administrative assistants was created to provide legal and administrative support to the panel. The DAP also was directed to render an annual written report containing findings of the audit and recommendations on improvements (Section 6086.11).

In June 1996, the results of the first "long-awaited audit" were announced. State Senator Quentin Kopp, leader of the campaign to abolish the mandatory bar, called the audit results "a damning indictment of the fiscal practices of the state bar." Bar leaders disagreed. "No fair reading of this report can support abolishing the bar," the organization's then-president, Jim Towery, concluded. The auditors themselves criticized "certain lapses in administrative oversight" but found no evidence of "bloated bureaucracy" or "wasteful management" (McCarthy, 1996, p. 4; see also Chiang, 1996a, 1996b, 1996c; Kopp, 1998; Steel, 1996; Towery & Zelon, 1996).[9]

Six months after the audit was completed, the California Bar Association faced new challenges. Perhaps the most serious threat, at least initially, was posed by Assemblyman William Morrow, a Republican from Oceanside, who called for an amendment to SB 1145 to make collection of bar dues for all programs (except discipline and administrative expenses) voluntary. In June 1997, Assemblyman Morrow also was one of several plaintiffs in a lawsuit filed in federal district court, *Morrow v. State Bar of California*, alleging that the bar's legislative activities violated the constitutional rights of its members. Three months later, Judge Garland E. Burell, Jr. dismissed the suit because the plaintiffs failed to show "that they have been forced to make or support politically expressive acts of the state bar" (Beitiks, 1997, p. 1). Although the case was dismissed, it publicly highlighted dissatisfaction with the bar's use of mandatory dues to fund lobbying activities and, thus, challenged the organization's legitimacy.[10] Assemblyman Morrow was especially incensed by the bar's support for four bills, including AB 250, Assemblywoman Sheila Kuehl's measure, which, if passed, would have created six exemptions to the 1975 Medical Injury Compensation Reform Act's (MICRA) $250,000 limit on physician liability for noneconomic damages. The MICRA reform package was a high-profile political dispute in California in 1997 (Guilford, 1997, p. 8).

Additional challenges to the mandatory state bar occurred in 1997 and 1998. On October 11, 1997, California Governor Pete Wilson vetoed the

bar's annual bill authorizing collection of dues from the state's lawyers. With no means of collecting dues, the organization was faced with the possibility of exhausting its funds by the summer of 1998 (K. O. Beitiks, personal communication, April 28, 1998). Steve Nissen, the new state bar executive director, eliminated 45 staff positions in February 1998 in an attempt to save $3 million in operating costs. Another 82 vacant positions were not filled. Nearly all remaining employees were slated to receive 60-day layoff notices during the spring and summer of 1998 (McCarthy, 1998, p. 13).

To resolve the funding crisis, Assemblyman Robert Hertzberg, a Democrat from Van Nuys, introduced a bill, AB 1669, to divide the existing bar into mandatory and voluntary components. In response to the bill, Assemblyman Morrow introduced four sets of amendments that, among other things, would have restricted the bar's activities to "core functions." "My amendment would plug a giant loophole that allows the state bar to lobby," he said. Despite Morrow's efforts, however, the amendments subsequently were tabled on a motion by Assemblyman Kevin Shelley, a Democrat from San Francisco. In discussing his opposition to the Morrow amendments, Assemblyman Hertzberg said they were procedurally improper because they were designed to accomplish goals that Morrow was unable to advance through other means, namely, the elimination of all lobbying activities and a severe reduction in bar dues. To lessen the possibility of further challenges to AB 1669, Assemblyman Hertzberg agreed to remove an urgency requirement from the bill (which would have allowed the measure to take effect immediately, thereby enabling the bar to collect dues in 1998 and continue to operate). He said the urgency provision could be reinstated once the bill moved into the Senate (McCarthy, 1998, p. 13).

As of this writing, the Hertzberg bill was still pending and the state bar faced the likelihood of continued layoffs and depletion of funds (K. O. Beitiks, personal communication, April 28, 1998; "Court Won't Rescue Bar," 1998, p. A8). Whatever eventually happens, the lesson to be learned from California is that a mandatory bar association's immersion in proactive lobbying activities and political imbroglios leaves it especially vulnerable to partisan legislative attacks. Ultimately, the perception that a professional licensing board is engaged in activities allowing nondemocratic elements of the regime, in this case lawyers, to lobby for their own ends—perhaps at the expense of persons who are not members of the profession—all but ensures attacks on the legitimacy of the board itself.

MASSACHUSETTS

Of the three state bar associations examined herein, the 19,000-member Massachusetts Bar Association is the only one that is voluntary. Founded in 1910, the association "provides public service opportunities and educational programs across the state" through participation in the association's sections and committees. Membership privileges include special rates on professional liability insurance, discounts on continuing legal education seminars, and access to a variety of legal publications (Massachusetts Bar Association, 1997). Owing to its lack of authority in disciplinary enforcement matters, the Massachusetts Bar Association has faced no direct challenges to its existence.

The relevant statutes governing lawyer discipline in the state were revised in May 1997 and went into effect on July 1, 1997. According to the Annotated Laws of Massachusetts (ALM) (1997) Desk Book, Item No. 74, "Bar Discipline and Clients' Security Protection," Section 1, any lawyer who practices law within the Commonwealth of Massachusetts "shall be subject to this court's exclusive disciplinary jurisdiction." In a subsequent section, the Supreme Court divided responsibility for lawyer discipline into six disciplinary districts, each vested with authority for handling complaints in the district where the lawyer maintains his or her principal office (Section 2).

The key provision of Item 74, Section 5 (ALM, 1997), created the Massachusetts Board of Bar Overseers to act on all matters of lawyer discipline within the commonwealth. The number of members, their designation as lawyers or nonlawyers, and other "balancing" considerations were left to the discretion of the court with the exception that the court "shall give appropriate consideration to reasonable geographical distribution of appointees among disciplinary districts."[11]

According to Arnold Rosenfeld, chief counsel of the Massachusetts Board of Bar Overseers, an informal practice of appointing 12 representatives to the board—8 lawyers and 4 nonlawyers—has arisen in the state in recent years. Similarly, the court typically appoints three members—two lawyers and one nonlawyer—to hearing committees, which adjudicate individual cases. Although the Supreme Court is not required by law to appoint a lawyer when a lawyer position is open on the board or a nonlawyer when a nonlawyer position is open, the court finds that this practice ensures greater public confidence in the disciplinary process (A. Rosenfeld, personal communication, September 10, 1997).

Section 5 vests the Board of Bar Overseers with discretion to "investigate the conduct of any lawyer within this court's jurisdiction either on its own motion or upon complaint by another person." The board also can engage in a variety of activities: appoint a chief bar counsel; appoint one or more hearing committees; appoint a special hearing officer; review and revise the conclusions and recommendations of hearing committees or a special hearing officer; adopt and publish rules of procedure and other regulations; may, but need not, consult with local bar associations; and "may perform other acts necessary or proper in the performance of the Board's duties" [Section 5 (3) (a)-(m)].

The lesson to be learned from Massachusetts, unlike states where bar membership is mandatory, is that lawyer discipline is less controversial when such matters are handled by an entity separate and apart from the organized bar. Moreover, by allowing for public participation, at least the perception of impropriety is minimized.[12] Whether this bifurcation of responsibility results in greater security for clients and the general public than the protections afforded by a system where the bar disciplines its own members remains to be seen.

THE MEDICAL PROFESSION

For more than a century, dating back to the first modern Medical Practice Act in Texas in 1875, state governments have entrusted the protection of the public's health care to state medical boards. These boards serve as the first line of defense against the unprofessional, improper, and incompetent practice of medicine. The role of state medical boards is crucial because they have sole responsibility for licensing and disciplining physicians and health care professionals (Johnson & Jones, 1993, p. 19).

State medical boards generally consist of physician and public members who are, in most instances, appointed by the governor. Until the 1970s, boards traditionally were independently structured, exercising all licensing and disciplinary powers. By 1990, between 30% and 40% of the medical boards in the United States had become part of larger umbrella agencies, such as a department of health, which exercised various levels of responsibility or functioned in an advisory capacity. Most boards currently employ an administrative staff that includes an executive officer, attorneys, and investigators, with some legal services provided by the state attorney general. Funding for medical board activities comes from

physician licensing and registration fees, as well as from fines imposed as a result of disciplinary actions (Bianco, 1993).

Through the licensure process, state medical boards ensure that all practicing physicians have appropriate education and training. Although requirements for licensure vary among the states, most require successful completion of a rigorous national exam (frequently supplemented by a separate state exam), evidence of medical education and training, and a detailed statement of a person's past work history. In addition, applicants for licensure must reveal any past medical history that may affect their ability to practice (including the use of habit-forming drugs and emotional or mental illness), arrests, and convictions. After physicians are licensed in a given state, they must reregister periodically to maintain their active status. During the reregistration process, some physicians are required to show participation in a continuing medical education program (Federation of State Medical Boards of the U.S. [FSMB], 1996b).

By serving as gatekeepers of the profession, medical boards are responsible for ensuring that physicians abide by recognized standards of professional conduct. Medical boards receive complaints about physicians from public consumers, malpractice data, information from hospitals and other health care institutions, and reports from government agencies. When a board receives a complaint, it has the power to investigate, to hold hearings, and to impose some form of discipline, such as fines, mandatory continuing medical education, or medical treatment. In egregious cases, the board can seek to suspend or revoke a license. All state statutes include provisions of the Medical Practice Act, which define standards of unprofessional conduct.

For more than a decade, state medical boards have been the subject of considerable scrutiny and criticism (Ameringer, 1996, pp. 17-22). As ostensible gatekeepers of the public's health care, medical boards have been harshly accused of failing to fulfill their responsibility. Various organizations contend that medical boards are failing to enforce standards of professional conduct or rendering inappropriate disciplinary action against physicians guilty of incompetence or substance abuse (see, e.g., Jeffrey 1998; Wolfe, 1985).

One of the most intensive reviews of the role of state medical boards in recent years was conducted by the inspector general (IG) of the Department of Health and Human Services (DHHS) at the request of the U.S. Congress. Motivated by heightened national concerns about malpractice, the quality of medical care, and the oversight role of state medical boards,

in January 1989 the House Subcommittee on Regulation, Business Opportunities, and Energy of the Committee on Small Business requested that the IG assess the disciplinary practices of medical boards. On June 8, 1990, the subcommittee held a hearing that focused on physician discipline, highlighted the performance of medical boards, and also presented findings from the IG review.

As the hearing revealed, the IG's review addressed physician disciplinary actions exclusively. The review began with a survey mailed to a random sample of eight states (including California), followed by site visits to the four states with the largest number of practicing physicians and, finally, discussions with board officials in other states and in three Canadian provinces (Government Printing Office [GPO], 1990, p. 63). The IG also examined disciplinary data provided by the boards to the FSMB.[13]

As a result of the study, the IG concluded that state medical boards had improved in their disciplinary enforcement activity in recent years, albeit significant problems still existed. The IG compared activity from 25 years ago—when medical boards focused attention entirely on licensure responsibilities and on developing and administering their own licensure exams—with the boards' current practices. Unlike earlier periods, during the late 1980s medical boards paid considerably more attention to disciplinary activities. "Nearly all boards now have the authority to revoke and suspend physicians' licenses, to issue emergency suspensions, to impose probations, and to invoke other lesser forms of discipline, such as reprimands, letters of concern, or fines," the IG observed (GPO, 1990, p. 99).

Despite praising medical boards' performance, the IG stressed that, because no method existed to address a board's actual performance in disciplining professionals, it was impossible to determine the number of physicians that state medical boards actually disciplined each year. "Medical boards typically do not prepare and issue data that allows for meaningful assessments of performance. Most boards issue annual reports, incorporating some statistical information, but this information tends to be fragmented and minimal," the IG concluded (GPO, 1990, p. 99).[14]

Recent criticisms of state medical boards have focused on the dominant presence of physicians on boards and the failure to disseminate information—particularly disciplinary or malpractice action—that was generally inaccessible to the public (Weiler, 1991; Wolfe, 1985). With the exception of Rhode Island, most medical boards in the United States are primarily composed of physicians.[15] In the 1980s, FSMB developed and provided to state medical boards a publication entitled *The Elements of a Modern Medical Board*, which argued that public members should serve

on medical boards. According to FSMB, public representation of 25% or more would provide reasonable input from consumers (GPO, 1990, p. 39).

Critics and consumer advocates continually argue that physicians on medical boards are reluctant to punish fellow physicians or disclose information about their practices and abilities. Because medical boards essentially serve as consumer protection agencies, they should not be dominated by doctors ("RX: A Shakeup," 1995, p. 6B). One organization, Stop Hospital and Medical Errors (SHAME), founded in 1986 by victims of medical negligence and their families, contends that the medical profession largely polices itself, to the detriment of the public. A SHAME representative addressing the House subcommittee in 1990 remarked that "whether you are talking about state medical board or peer-review organizations or impaired physicians programs or in-hospital peer review, quality assurance programs, risk management programs, those are largely doctor-run supervised programs" (GPO, 1990, p. 12). On the opposite side of the issue, medical associations contend that public members serving on state boards do not guarantee more stringent discipline against unprofessional and incompetent physicians. In fact, public members on the boards vote consistently not to stiffen penalties against physicians (Benson, 1995, p. 3B).

The dissemination of physician information to the public has become a growing controversy between the physician's privacy and the public's right to know. How much of a doctor's history should be made public has been debated for several years—especially in the California legislature (Ostrom, 1997, p. 1A). Some medical boards have recently made physician information available to consumers through Web sites on the Internet and toll-free telephone numbers. Arguing on behalf of physician privacy, advocates contend that open accessibility to now secret medical physician information increases risks for doctors. They contend that many claims against physicians are meritless and in those cases that include settlements, defendants do not necessarily admit fault. In addition, many physicians assert that certain specialists, such as obstetricians, incur a much higher risk of lawsuits, and some doctors treat predominantly high-risk patients. Moreover, some claims may be nothing more than nuisance suits (Ostrom, 1997, p. 1A). To counter these claims, consumer advocates argue that releasing information on settlements is crucial because the vast majority of malpractice claims are settled before a court verdict is reached. They also contend that the lack of available information is a method of protecting doctors rather than protecting the public and, in fact,

investigations of physicians are only halfheartedly conducted ("Medical Boards Need to Intervene Faster," 1996, p. 6).

Two organizations that serve as watchdogs of disciplinary operations of state medical boards are FSMB and the Public Citizen's Health Research Group. Founded in 1912, FSMB is a national, voluntary association of state medical boards composed of 66 members. FSMB serves as the representative body and forum for physician licensing and disciplinary boards and provides a wide range of services and activities to the boards. For example, FSMB provides the U.S. Medical Licensing Examination (USMLE) and the Special Purpose Examination (SPEX) to meet licensing examination needs of the boards (FSMB, 1996a). FSMB also collects, maintains, and reports disciplinary actions taken by boards through the nationally recognized Board Action Data Bank.[16] These actions are reported to the federation by state licensing and disciplinary boards, Canadian licensing authorities, the United States Army, the DHHS, the Educational Commission for Foreign Medical Graduates, and other authorities.

FSMB provides a yearly summary of disciplinary actions against physicians collected from state medical boards.[17] In 1996, the federation documented 3,821 prejudicial actions taken against physicians for medical practice act violations and 611 nonprejudicial actions involving 533 physicians (FSMB, 1997a). The federation also provides a Composite Action Index (CAI) to assess each board's disciplinary activity over time.[18] According to James R. Winn, M.D., the federation's executive vice president,

> the structure and funding of medical boards have a direct impact on their CAI. Independent or semi-autonomous boards have higher CAIs than those that are subordinate or advisory. Boards with the authority to set their own fees, control and direct the activities of their staffs and adopt their own budgets maintain higher CAIs on average than those boards without these powers. Based on the differences in board structure, funding, staffing, and the state statutes under which each entity is mandated to operate, one jurisdiction or board cannot be compared to another. (FSMB, 1997a)

As for the Public Citizen's Health Research Group, this organization, founded by Ralph Nader, issues a yearly national ranking of state medical boards based on serious doctor disciplinary actions. The group has criticized what it considers to be inaction by medical boards in severely disciplining doctors guilty of incompetence as well as substance and patient abuse. The group argues that many medical boards and other regulatory

agencies have either entirely failed to catch doctors guilty of incompetence, drunkenness, or patient abuse, or have penalized them with figurative slaps on the wrist, such as fines or reprimands (Public Citizen's Health Research Group, 1996a, p. vii). The group also criticizes the National Practitioner Data Bank, a federal repository of disciplinary actions by state medical boards and federal agencies, because information is kept secret from patients and almost all physicians. To provide more information to the public, the group has established its own publicly available data bank of doctors who have been disciplined and issues a series of annual reports entitled *Questionable Doctors*, which provides information broken down by individual states.[19]

As was the case with the legal profession, it is instructive to examine state professional licensing and disciplinary boards in Georgia, California, and Massachusetts. The structure, organization, and function of medical boards in these jurisdictions vary considerably, yet some commonality exists. In each case, the move toward greater public participation in disciplining professionals has been unmistakable in recent years.

GEORGIA

The Composite State Board of Medical Examiners in Georgia was created by statute in 1909. The board operates semiautonomously. Its operations are administered by the Examining Boards Division in the Office of the Secretary of State (J. Sprouse, personal communication, July 22, 1997). The board licenses and regulates physicians, osteopaths, respiratory therapists, paramedics, cardiac technicians, and physician assistants.[20]

Board membership consists of 13 members: 12 physicians and 1 public member appointed by the governor and confirmed by the Georgia Senate. Ten of the 12 physicians hold medical degrees and the remaining two hold doctor of osteopathy (D.O.) degrees. The public member must have no connection with the practice of medicine. Board members serve 4-year terms, with no limit on serving consecutive terms. The board can nominate a president and vice president, an executive director, and a medical coordinator. The executive director's responsibility is to review all matters that come before the board, to organize and appoint board committees, to evaluate all complaints received and processed for investigation (including authority to appoint or request of the joint secretary any necessary investigators), and to evaluate investigative reports and authorize the issuance of notices of hearing by the attorney general. The medical

coordinator serves as the board's medical expert by providing medical expertise and assistance to the executive director and medically evaluating investigative reports. The board also includes a Physician's Assistants Advisory Committee. This committee reviews matters before the board that relate to physician's assistants, including applicants for physician assistant certification and recertification and education requirements, as well as proposed board regulations concerning physician's assistants (State of Georgia, 1995, pp. 5-6).

The board has the authority to discipline a physician licensed in Georgia if that physician has engaged in 1 or more of 12 specific activities listed as "unprofessional conduct," as defined in the law. The board has the power to conduct investigations either through the joint secretary of the boards or independently (State of Georgia, 1996). It receives an average of 500 complaints yearly, which are kept private and confidential. The investigations and findings from complaints are also private unless a public action occurs, such as revoking a license, publicly reprimanding a professional, or conducting a hearing. If the board investigates a complaint and does not find any violation of professional conduct, information on the complaint is never made public. Once a case is completed, the information is still protected from the public. According to William G. Miller, joint secretary of the boards, confidentiality protects both the complainant and the license holder. If a physician is found guilty after a hearing, disciplinary action is taken (W. G. Miller, personal communication, August 21, 1997).

On the basis of the Public Citizen's Health Research Group rankings from 1991 to 1995, Georgia ranked in the Top 10 of medical boards taking disciplinary action against physicians nationally (Public Citizen's Health Research Group, 1996b). In 1996, Georgia ranked 19th, with 67 serious actions. The group also included Georgia in its category of best states with the highest serious disciplinary rates (Public Citizen's Health Research Group, 1997a).[21] FSMB reported that in 1996, Georgia had a total of 82 prejudicial actions and 13 nonprejudical actions; 73 physicians incurred prejudicial actions and 11 physicians incurred nonprejudicial actions. The federation's CAI for Georgia was 5.18 (FSMB, 1997b). According to the records maintained by the Examining Boards Division, the medical board received a total of 549 complaints and issued 76 sanctions in fiscal year 1996.[22] The sanctions included any type of disciplinary action, such as public/private reprimand, suspension, revocation, or probation (W. G. Miller, personal communication, August 21, 1997).

CALIFORNIA

The Medical Board of California was organized and authorized in 1867. As in Georgia, this board is semiautonomous, with its operations administered by the California Department of Consumer Affairs. The board licenses and regulates physicians, surgeons, and certain allied health professions. It has sole oversight responsibility for 103,000 licensed physicians.[23] The requirements for the licenses are defined in Article 4 of the Medical Practice Act (California Department of Consumer Affairs, 1995, p. 205).

Board membership consists of 19 members: 12 physicians and 7 public members. All the physicians and 5 of the public members are appointed by the governor and confirmed by the state senate. The Senate Rules Committee and the Speaker of the Assembly appoint the remaining two public members. All physician board members must be licensed physicians and surgeons in the state; no one can hold any interest in a college, school, or institution engaged in medical instruction. Four of the physician members must hold faculty appointments in a clinical department of an approved medical school in the state, but not more than four board members can hold full-time appointments to the faculties of such medical schools (California Department of Consumer Affairs, 1995, Business and Professions Code, chap. 5, secs. 2001 and 2007, pp. 186-187).

The board consists of two divisions: the Division of Licensing (DOL) and the Division of Medical Quality (DMQ). In June 1995, the DOL was reorganized and can now access the National Practitioner Data Bank.[24] The division also implemented a new Applicant Tracking System, a computerized database designed to track physicians' applications as they satisfy each legal requirement and progress toward licensure (California Department of Consumer Affairs, 1996a).

The DMQ is the enforcement arm of the medical board.[25] On January 1, 1996, legislation was passed creating a Diversion Program in the division. It allows impaired physicians who are suffering from alcoholism or drug addiction to participate in the program rather than face board discipline for substance abuse. Physician participants in the program are also allowed, when appropriate, to continue to practice medicine. About 70% of participants are self-referred and their status is kept completely confidential from the disciplinary arm of the medical board (California Department of Consumer Affairs, 1996a). In addition, no physician's license is affected as a result of participating in the program; however, legislation stipulates

that the medical board may continue to investigate and take disciplinary action against a physician who is enrolled in the program for violations unrelated to substance abuse.

The board receives about 12,000 complaints yearly. Complaints and investigations of the board are not matters of public record. A case becomes public only if the board files a formal accusation against a physician's license. This occurs after the complaint has been received, investigated by the board, and one of the deputy attorney generals reviews the case and finds evidence to proceed. California is 1 of 15 states requiring a standard of clear and convincing evidence as opposed to a preponderance of evidence (C. Cohen, personal communication, August 21, 1997).

The Medical Board of California has received intense criticism in recent years for its board composition and disciplinary operations ("Senate Bills Would Help," 1994, p. A5). The Consumers for Quality Care, an outspoken critic, has argued that the physician majority of the board has been reluctant to punish fellow physicians or even to disclose information about them ("RX: A Shakeup," 1995, p. 6B). In 1995, California Senate Bill 486 (July 24) was introduced into the legislature, calling for 11 public members (a majority) as opposed to the present 7 (Benson, 1995, p. 3B). The medical board and the California Medical Association opposed the bill, arguing that the change in board structure would be largely cosmetic, with no substantive effect on health care or doctor discipline in the state. It did not pass (Benson, 1995, p. 3B).

In 1993, a state investigation revealed that the medical board had been literally throwing away some complaints from consumers without investigation ("Assembly Bill Trimming," 1995, p. 3B). The following year, FSMB reported that California had one of the highest rates of consumer complaints and one of the lowest rates of doctor discipline. Also in the same year, after a lawsuit was filed by three California newspapers, the board was ordered to release its own discipline records to the public. In a review of some of the state's most egregious malpractice cases, *The Sacramento Bee* found that many of the judgments were missing from the board's computerized records (Philip, 1995, p. B1). In response to the criticisms, members of the California legislature debated a bill in May 1997 that would have significantly expanded public access to information about physicians. If it had passed, the bill would have required the state to publish through the Internet a volume of records, including court judgments, malpractice settlements, hospital disciplinary actions, and any cases against doctors the California Medical Board referred to the state attorney general. The bill also would have required the medical board to

report any malpractice court award or settlement or arbitration award reported to the board after January 1, 1998, any disciplinary actions taken by the board or another state or jurisdiction during the last 10 years, and any hospital actions that revoked a doctor's hospital staff privileges for a medical reason during the last 10 years (Ostrom, 1997, p. 1A). Currently, the medical board will release information to telephone callers about cases in which doctors have been ordered by a court to pay malpractice claims of $30,000 or more or when the attorney general formally accuses a physician. (This information also became available through the Internet in 1997 [Ostrom, 1997, p. 1A].)

According to the annual report of the Medical Board of California, 999 malpractice reports were filed against physicians and surgeons in fiscal year 1995-1996.[26] An action summary by the Division of Medical Quality for complaints/investigations and administrative actions for fiscal year 1995-96 indicates that a total of 11,497 complaints were received and 9,751 were closed. The medical board opened 1,998 investigative cases for the fiscal year, closed 2,043 cases, and referred 510 cases to the attorney general. A total of 329 administrative filings and 345 administrative actions occurred in fiscal year 1995-1996.[27]

In 1996, the Public Citizen's Health Research Group ranked the state medical board 27th nationally for serious disciplinary actions taken against physicians.[28] The group included California among 11 states that experienced a significant improvement in the rate of serious disciplinary actions from 1991 to 1996 (Public Citizen's Health Research Group, 1997a).

MASSACHUSETTS

The Massachusetts Board of Registration in Medicine was organized by statute in 1894. Unlike medical boards in Georgia and California, the Massachusetts medical board operates separate and apart from any state agency. Pursuant to its enabling statute, the board exercises responsibility for licensing and registering 28,000 physicians and 500 acupuncturists.[29] Board membership consists of seven persons: five physicians licensed by the state and two nonphysicians with no close physician contact in the family. All board members are appointed by the governor and serve 3-year terms, with a limit of two consecutive terms (A. Fleming, personal communication, July 15, 1997).

Similar to the medical board in California, the Massachusetts Board of Registration in Medicine has received numerous criticisms about board

operations, particularly disciplinary actions (L. Fenichel, personal communication, July 30, 1997). The Public Citizen's Health Research Group has consistently ranked the board near the bottom nationally on the number of disciplinary actions taken against physicians (Public Citizen's Health Research Group, 1996c). In 1994, a "Spotlight" series in *The Boston Globe* highlighted weaknesses in the board's regulatory system. The series found that incompetent doctors continued to practice after being sued repeatedly and successfully for malpractice and consumers were unable to find out critical information about their physicians (Kong, 1994, p. 1; 1995a, p. 13; 1995b, p. 14; 1996a, p. 13; 1996b, p. A16).

In response to the negative media exposure, the secretary of consumer affairs appointed a blue-ribbon task force in July 1991 to review the policies and operating procedures of the board (Massachusetts Board of Registration in Medicine, 1993, p. 14). The task force made recommendations to assist the board in improving its operations. Among its recommendations, the task force suggested that the board increase certain fees, including the biennial doctor's renewal, and establish a trust fund account so that 40% of revenues generated could be used exclusively for board operations. The task force also recommended that the disciplinary unit be restructured into what is now called the "enforcement division," with two units (Massachusetts Board of Registration in Medicine, 1993, p. 14).

To further implement changes, in 1994 the Massachusetts Medical Society filed a bill to create a physician profile system. The bill passed the full House the following year, and the system began operating in November 1996. Physician profiles include information on whether a doctor is certified in a specialty, which hospitals have granted the doctor admitting privileges, and any board disciplinary actions. Data on past malpractice awards against a particular physician and comparative information on a typical award for a doctor in that specialty are also included (Kong, 1996a, p. 13). Consumer advocates and state officials welcomed the legislation and applauded the medical society for taking a revolutionary stand in providing consumers with detailed information about physicians. According to the Massachusetts Public Interest Research Group, which had pushed consistently for a more active state medical board, the bill indicated that even the medical board realized the need for consumers to have more and better information about physicians, and the state understood the necessity of aggressively policing incompetent physicians (Kong, 1994, p. 1).

Unlike the medical boards in Georgia and California, the Massachusetts Board of Registration in Medicine does not have available statistical information on disciplinary actions taken against physicians since 1993.

Disciplinary data were only available for fiscal years 1990-1993.[30] In fiscal year 1993, the board issued 42 statements and disciplined 50 physicians. In the area of patient care assessment data, from 1990 through 1993, a total of 2,044 major indictments were reported to the board.[31] However, Massachusetts has become the first state in the nation to offer its residents malpractice, disciplinary, and biographical information about doctors through both a toll-free telephone number and a Web site (Mohl, 1997, p. B1). In 1996, the Public Citizen's Health Research Group ranked the board 43rd, based on 73 serious actions. The group also included the board in its category of worst states with the lowest serious disciplinary rates.[32]

THE FUTURE OF THE LEGAL AND MEDICAL PROFESSIONS

Judging by the examples discussed herein, the legal and medical professions will continue to face direct and indirect challenges to their legitimacy in the years ahead. If the theoretical justification for allowing nondemocratic groups to exercise regulatory authority over their own professions is based on a concern for protecting the public interest, the ability of licensing boards to protect citizens from incompetent or unethical practitioners is suspect. Futhermore, the apparent inability or unwillingness of licensing boards to police their members in other areas of practice and conduct leaves those boards vulnerable to the charge of insulating professionals from democratic controls and engaging in the paternalism that Milton Friedman deemed anathema. The end result is that the public mistrusts professional licensing boards as much as it mistrusts professionals themselves, viewing them as a mechanism for protecting the privileged elite at the expense of the "common man."

As for the more sinister question of whether professional licensing boards have been captured by the professionals they supposedly police, Lord Acton's famous aphorism that "power tends to corrupt, and absolute power corrupts absolutely" readily springs to mind (quoted in Heywood, 1994, p. 20). Although some evidence exists that legal and medical boards have not been equal to the task before them, the question of reform presents a dilemma (see, e.g., ABA, 1992, p. 1; Ameringer, 1996, pp. 28-32). Unfortunately, placing citizen members on licensing boards does not ensure that the public interest is protected, although improved protection is one possible result. (Another possible result is that placing a citizen on the board may ensure that the citizen member feels accountable to the

appointing authority in lieu of the abstract "public interest.") Similarly, in certain instances placing licensing boards completely under the auspices of a state agency may be tantamount to exchanging one private interest for another. That is, the board may be captured by public administrators within a state agency instead of being captured by members of the profession. This disturbing development may do little or nothing to solve the problem of protecting the public. If no one can be counted on to safeguard the "public interest," however it might be defined, the question always becomes an issue of balancing competing private interests. In other words, how can the rights of the public to receive competent, effective service from professionals be weighed against the rights of professionals to practice free from harassment, embarrassment, and false accusations that damage reputations and livelihoods?

This dilemma of balancing competing interests when no heroic, neutral arbiter can be found is not a new problem. The Founders of the American republic faced exactly the same conundrum when they sought to forge a new nation from 13 disparate elements more than two centuries ago. As Publius wrote in "Federalist 51," the answer to what at first seems to be an intractable problem is to conclude that "ambition must be made to counteract ambition." By balancing competing interests against each other, the interests of everyone arguably can be protected.

> This policy of supplying, by opposite and rival interests, the defect of better motives, might be traced through the whole system of human affairs, private as well as public. We see it particularly displayed in all the subordinate distributions of power, where the constant aim is to divide and arrange the several offices in such a manner as that each may be a check on the other—that the private interest of every individual may be a sentinel over the public rights. (Hamilton, Madison, & Jay, 1961, p. 322)

If this compromise is less than a complete victory over the depravities of the human character, at least it is preferable to allowing one interest to dominate others.

In light of the trends reported in this article, professional licensing boards will have to accept public members in the future, although this action alone will not suffice to rectify real or perceived abuses. At the same time, to ensure more than mere cosmetic change, citizen members of licensing boards must be elected or otherwise chosen (e.g., through a lottery system) where a certain degree of chance or popular appeal, not cronyism toward the appointing authority, will be the order of the day. Afterward, when the interests of nondemocratic professionals on the

board are balanced against the interests of democratically selected citizen members, conflicts will inevitably result, just as they do in the American political system. Yet, from these conflicts, perhaps a more moderate approach to licensing and disciplining the legal and medical professions may emerge. Ideally, professional members of the board will protect the interests of the profession, and citizen members will ensure that professionals do not become too insulated and blind to the needs of the public. As an added benefit, confidence in the system of licensing and disciplining professionals may result.

In the legal profession, states that retain mandatory bar associations must allow for some form of nonlawyer participation in disciplining lawyers, as recommended in the McKay Report, if the public is to have confidence in the fairness of the process. Even in states where the bar does not retain control over lawyer discipline, it is politically prudent to provide an outlet for public participation and input into the state's disciplinary system. Partly because the citizenry has much more regular interaction with them (and hence more occasions to be reminded of perceived problems with the licensing process), the issue of fairness is even more acute with physicians.

The trend toward more openness and public responsiveness in professional licensing and disciplinary systems shows no signs of abating. Stanford University law professor Ronald L. Gilson has concluded that the days when lawyers exercised dominant "market power" over clients have disappeared. It is a comment that applies equally well to physicians. As the supply of lawyers and physicians has mushroomed in recent decades, demand-side economics has dictated changes in the way these professions operate. The proliferating ways in which timely information is disseminated as well as the burgeoning moves to increase the roles of citizens in disciplinary actions have given the public more power and control over these professionals than ever before. Professor Gilson's (1990) most dire warning to his own profession could have as easily come from the pen of Milton Friedman back in the 1950s: "The message I offer is that a necessary condition for professionalism is market power. We had better start paying attention to those who have it" (p. 916).

NOTES

1. Undoubtedly the most famous definition of political power was provided by John Locke (1947):

> Political power, then, I take to be a right of making laws, with penalties of death and consequently, all less penalties for the regulating and preserving of property, and of employing the force of the community in the execution of such laws, and in the defence of the commonwealth from foreign injury, and all this only for the public good. (p. 122)

2. To give a rough sense of the numbers of elected and unelected individuals who wield political power in the regime, consider that our 86,743 political jurisdictions—which, interestingly, are actually little more than half the number of jurisdictions in existence 50 years ago(!)—have created 511,034 elective offices (U.S. Department of Commerce, 1995). Even under the spell of "reinventing government," total civilian employment in the public sector has crept past 18,745,000 (U.S. Department of Commerce, 1995). These elected and appointed public servants collectively wield the major share of the regime's political power.

3. On February 14, 1997, Secretary of State Lewis Massey forwarded a bill to the Georgia General Assembly that contained his recommendation for deregulating the boards under his control. The bill died and Secretary Massey subsequently sent a letter to all the boards stating that he would not raise the issue of deregulation again (Governor's Commission on the Privatization of Government Services, 1997). For more information on Georgia House Bill 1296 (January 16, 1998), see Massey (1997, p. 21), Miller and Pruitt (1998, p. C3), or visit the Secretary of State Home Page (1997) at http://www.gabar.org.

4. Today, the original 54 sections of the Model Rules serve as the basis for most states' binding professional codes of conduct. Reflecting an increased interest in, and awareness of, ethical issues, the American Bar Association (ABA) adopted nearly 20 amendments to the rules or their accompanying comments from 1983 to 1994, and five new rules or parts of rules were added. Moreover, the ABA Standing Committee on Ethics and Professional Responsibility has issued 58 formal opinions elaborating on the rules since 1983 (see "Changing Times, Changing Rules," 1997, p. 62; Martinez, 1998, pp. 702-704).

5. For an example of the practical effects of the Clark Report, see Samborn (1998, p. 30).

6. The Clark and McKay reports remain the most influential and widely discussed ABA publications on professional standards and lawyer discipline, although they are by no means the only documents available. Other ABA reports on legal ethics and attorney discipline include *Model Federal Rules of Disciplinary Enforcement* (ABA, 1978), *Professional Discipline for Lawyers and Judges* (ABA, 1979), *Outreach by Lawyer Disciplinary Systems* (ABA, 1990), *Standards for Imposing Lawyer Sanctions* (ABA, 1991), *Model Rules for Judicial Disciplinary Enforcement* (ABA, 1995c), *The Judicial Response to Misconduct* (ABA, 1995a), *Survey on Lawyer Discipline Systems (1993-94)* (ABA, 1996c), *Directory of Lawyer Disciplinary Agencies and Lawyers' Funds for Client Protection* (published together in one volume) (ABA, 1996a), and *Model Rules for Lawyer Disciplinary Enforcement* (ABA, 1996b). Echoing the concern for public legitimacy so prominently discussed in the McKay Report, the latter publication in this list recommended the appointment of several nonlawyers to a disciplinary board established by a state's supreme court:

> A combination of lawyers and non-lawyers on the board results in a more balanced evaluation of complaints. Currently more than two-thirds of all jurisdictions involve public members in their disciplinary structure. Participation by non-lawyers increases the credibility of the discipline and disability process in the eyes of the public. There is a human tendency to suspect the objectivity of a discipline body [*sic*] composed solely of members of the respondent's professional colleagues. Involving public members helps allay that suspicion. (ABA, 1996b, Rule 2, Commentary, p. 8)

7. Although Rule 4-101 of the Canons of Ethics authorizes the State Bar of Georgia "to maintain and enforce . . . standards of conduct to be observed by the members of the State Bar of Georgia and those authorized to practice law in the State of Georgia and to punish violations thereof," Rule 4-102 empowers the Georgia Supreme Court to "impose any of the levels of discipline set forth above following formal proceedings against a respondent," thus making the court the final arbiter on questions of lawyer discipline (State Bar of Georgia, 1997, p. 40-H).

8. Georgia's new rules were similar to new rules implemented in neighboring states, most notably South Carolina. See, for example, H. B. Richardson, Jr. (1998), pp. 1, 4.

9. For additional discussions of efforts to dismantle the mandatory bar in California during the 1990s, see, for example, Hager (1990, 1991) and Holding (1992).

10. An earlier case, *Keller v. State Bar of California* (1990), held that the state bar could engage in lobbying activities provided that no fees from mandatory assessments were used to fund such activities.

11. In relevant part, Section 5 provides that

> The Board shall consist of such number of members as the court may determine from time to time. The court, by order, shall request the submission of nominations to fill vacancies in such manner as it may determine. The Massachusetts Bar Association and each county bar association . . . may submit to this court in writing the names of two nominees for each vacancy on the Board. Any lawyer may submit in writing the names of nominees.

12. Beyond simply stating a concern with the appearance of impropriety, a 1997 study of the legal profession published by the Boston Bar Association catalogued a variety of problems in the practice of law, including incivility, lack of "professionalism," dubious or fraudulent billing practices, "alienation" in the profession, lack of proper mentoring for younger lawyers, and the deterioration of lawyers' tasks into mere technical exercises, among other concerns. Although these issues are not always directly related to disciplinary actions, they may eventually lead to poor performance and ethical lapses by lawyers (Hazard, 1997, p. A19).

13. The findings of the inspector general (IG) review were submitted to the subcommittee in a report entitled *State Medical Boards and Medical Discipline*, dated April 1990. The IG 1986 review focused on the licensure and disciplinary responsibilities of the boards and identified various vulnerabilities in both spheres (Government Printing Office [GPO], 1990, p. 82).

14. The IG listing of recommendations to state governments, the U.S. Department of Health and Human Services, Federation of State Medical Boards, and National Governors' Association, the Council of State Governments, and the National Conference of State Legislature, is included on pages 80-81 of the *State Medical Boards and Medical Discipline Report* (GPO, 1990).

15. In Rhode Island, board membership is split evenly between physicians and public members (N. Deary, personal communication, August 21, 1997).

16. As of 1995, the Board Action Data Bank contained more than 70,000 actions related to more than 25,000 physicians. To be included in the bank, an action must be a matter of public record or be legally releasable to state medical boards or other entities with recognized authority to review physician credentials. Among the actions included in the bank are revocations, probations, suspensions, and other regulatory actions, such as license denials or

reinstatements, consent orders, and Medicare sanctions (Federation of State Medical Boards, 1996a).

17. Two categories comprise the disciplinary actions: prejudicial actions and nonprejudicial actions. The first category covers three areas. First is loss of license or license privileges, which includes revocation, suspension, surrender or mandatory retirement of license, or loss of license privileges; second is restriction of license or license privileges, which includes probation, limitation, or restriction of license, or license privileges; and third is other prejudicial actions, which include modification of a physician's license, or license privileges that result in a penalty or reprimand to the physician. The second category, nonprejudicial actions, are actions that do not result in modification or termination of a license or license privileges. These actions are frequently administrative in nature, such as loss of a license due to lack of qualifications or a reinstatement following disciplinary action (Federation of State Medical Boards, 1997b).

18. This is a statistical calculation that has been used since 1991 and averages four activity ratios that measure disciplinary activity. The ratios include total actions/total licensed physicians, total actions/practicing in-state physicians, total prejudicial actions/total licensed physicians, and total prejudicial actions/practicing in-state physicians. The federation created the Composite Action Index (CAI) to combine the four ratios into a single composite ratio for each board. The CAI permits all relevant variables to contribute in a balanced way to a final figure that can be useful in measuring an individual board's disciplinary activity over time (Federation of State Medical Boards, 1997b).

19. The Public Citizen's Health Research Group's calculations of rates of serious disciplinary actions per 1,000 doctors by state is determined by taking the number of such actions and dividing it by the American Medical Association data on nonfederal medical doctors, and then multiplying the result by 1,000 to determine state disciplinary rates (Public Citizen's Health Research Group, 1997a).

20. The board exercises oversight responsibility for 23,000 physicians, 3,000 respiratory therapists, 4,000 paramedics, 1,000 cardiac technicians, and 1,200 physician's assistants to protect the public health and regulate the practice of medicine and osteopathy (W. G. Miller, personal communication, August 21, 1997).

21. Georgia nationally ranked 4th in 1995 and 1991, 8th in 1994, 10th in 1993, and 9th in 1992 (Public Citizen's Health Research Group, 1997b).

22. According to William G. Miller, Joint Secretary, Office of the Secretary of State of Georgia, Examining Boards Division, the state medical board handled the following number of complaints and dispositions: fiscal year 1995, 520 complaints and 79 sanctions; fiscal year 1994, 639 complaints and 65 sanctions; fiscal year 1993, 565 complaints and 102 sanctions; fiscal year 1992, 511 complaints and 111 sanctions (W. G. Miller, personal communication, August 21, 1997). Despite the board's efforts to address the complaints in an efficient, timely, and effective manner, some citizens have charged that the state medical board has not done enough to reduce a "substantial backlog of cases" (Miller & Pruitt, 1998, p. C3).

23. The board has some limited review over affiliated healing arts, such as lay midwives and research cycle analysts, arguably the two major nonphysician health care professions. By statute, the board theoretically exercises oversight of physician's assistants and regulatory dispensing opticians, although in practice complaints concerning those two professions are investigated by boards governing those fields (C. Cohen, personal communication, August 21, 1997).

24. The Division of Licensing (DOL) responsibility includes processing initial licensure applications; administering written and oral examinations; issuing licenses and certificates; administering the continuing medical education program, the student loan program, and the licensing programs for several allied health professions; approving graduate and undergraduate medical education programs; and disclosing information to the public regarding disciplinary actions (California Department of Consumer Affairs, 1996a).

25. The Division of Medical Quality (DMQ) is responsible for enforcing the disciplinary and criminal provisions of the Medical Practice Act and the administration and hearing of disciplinary actions; conducting disciplinary actions appropriate to findings made by a Medical Quality Review Committee, the division, or an administrative law judge; suspending, revoking, or otherwise limiting certificates at the conclusion of disciplinary actions; and reviewing the quality of medical practice performed by physician and surgeon certificate holders (California Department of Consumer Affairs, 1996a, 1996b).

26. This total reflects 870 reports filed by insurers; 110 by attorneys, self-reported, or by employers; and 19 reported by the courts. Coroners filed 14 reports and the health facility discipline filed 112. Sixteen reports resulted in criminal charges and convictions (California Department of Consumer Affairs, 1996a).

27. Total administrative filings included 28 interim suspensions, 1 temporary restraining order, 8 automatic suspension orders, 2 statements of issues to deny application, 16 petitions to compel a psychological exam, 4 petitions to compel a competency exam, 8 petitions to compel a physical exam, and 262 accusations/petitions to revoke probation. Total administrative actions included 62 revocations, 52 surrenders of license, 1 suspension, 29 probations with suspension, 129 probations, 1 probationary license issued, 67 public reprimands, and 4 other decisions (California Department of Consumer Affairs, 1996b).

28. California ranked 20th in 1995, 34th/35th in 1994, 32nd in 1993, 42nd in 1992, and 37th in 1991 (Public Citizen's Health Research Group, 1996a, 1997b).

29. Acupuncturists were first allowed to practice medicine in Massachusetts in 1973 under a board regulation that required an acupuncturist to be a physician or in the employ of a physician. In 1977, this regulation was amended to allow board-registered acupuncturists to practice in conjunction with supervising physicians, whose role was to give patients preliminary examinations and written referrals for acupuncture treatment. In January 1988, regulations were promulgated to allow acupuncturists to become licensed in the state (Massachusetts Board of Registration in Medicine, 1993). For more information, see Massachusetts Board of Registration in Medicine (1996).

30. In fiscal year 1992, 18 statements were issued and 39 physicians disciplined; in fiscal year 1991, 20 statements were issued and 25 physicians disciplined, and in fiscal year 1990, 19 statements were issued and 33 physicians disciplined (Massachusetts Board of Registration in Medicine, 1993, p. 4).

31. The major incidents reported in the two categories in fiscal years 1990-1993 are as follows: In fiscal year 1993, 407 in Category 1 and 56 in Category 2; in fiscal year 1992, 441 in Category 1 and 81 in Category 2; in fiscal year 1991, 462 in Category 1 and 80 in Category 2; in fiscal year 1990, 433 in Category 1 and 84 in Category 2 (Massachusetts Board of Registration in Medicine, 1993, p. 9).

32. The board ranked 40th in 1995, 37th in 1994, 45th in 1993, 46th in 1992, and 48th in 1991 (Public Citizen's Health Research Group, 1997b).

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