Licensure Challenges in Preventive Medicine

A Public Policy Issue

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Introduction

Preventive medicine is a unique medical specialty recognized by the American Board of Medical Specialties that employs a population-based approach to healthcare delivery. Physicians certified in preventive medicine often focus their disease prevention and health promotion efforts at both the individual and population levels. Preventive medicine physicians are uniquely trained in both clinical and population-based medicine and are required to earn a Master of Public Health (MPH) or equivalent degree during residency training. Thus, they enter medical practice with a population-based focus and are viewed as leaders in advancing outcomes-based practice in prevention and wellness. Many preventive medicine physicians are involved in one or more medical policy roles, such as establishing regulations, setting clinical standards, monitoring quality of care, and developing the evidence base for such policies.

A seminal article[1] reviewing challenges and opportunities in preventive medicine residency training summarizes the value of such roles for the specialty:

> no other medical specialty features a central focus on population medicine . . . preventive medicine (physicians are) experts in implementing preventive services and analyzing the impact of clinical systems on individual health care and population health outcomes.

This positions preventive medicine especially well, compared to other medical specialties, to address the challenges facing the U.S. healthcare system with regard to population health management, accountability for the health of populations and communities, and system redesign in the post–health reform era.

Preventive medicine physicians and others who practice population-based medicine assess the health status and needs of a target population, implement and evaluate interventions that are designed to improve the health of a population, and efficiently and effectively provide care at the population level. They rely on their medical training and clinical judgment in making medical decisions for the populations they serve. As a result, these physicians, like all others, require a medical license to practice medicine. What makes them unique is that many of them practice in settings that may not be viewed by state medical licensure boards as fulfilling the requirements for being engaged in the active practice of medicine.

Medical licensure is a state function that protects the quality of medical care delivered to patients and populations, a core competency area of preventive medicine residency training programs and a core element in the mission of state medical licensure programs. Many states are moving to require for medical licensure that all physicians be currently engaged in the active practice of medicine. As described below, it is now known that statutes in four states have strict language defining the term "active practice," and an additional 11 states have vague language that leaves open the question of whether the practice of preventive medicine meets the definition. Given that other states also are considering adding language regarding active practice as part of the movement toward "maintenance of licensure" standards, the potential scope of this problem for the discipline of preventive medicine is substantial.

The Accreditation Council for Graduate Medical Education (ACGME) defines clinical practice as

> the practice of medicine in which physicians assess (in person or virtually) patients or populations in order to diagnose, treat, and prevent disease using their expert judgment or in which physicians

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contribute to the care of patients by providing clinical decision support and information systems, laboratory, imaging, and related studies.[2]

Thus, the council recognizes that many physicians who do not routinely participate in direct patient care are still actively involved in clinical practice. The ACGME definition of clinical practice is sometimes at odds with the often narrow definitions of "clinical practice" and "active medical practice" determined by some state legislatures and medical boards.

These definitions hold particular importance for preventive medicine physicians because many within this specialty practice in settings outside of direct patient care, often in academic, research, government, public health, and other physician leadership positions. Because of these unique aspects of the field, preventive medicine physicians, as well as physicians in other specialties who practice nonclinical medicine, may experience difficulty obtaining a medical license solely because they do not meet state definitions of having been in "active medical practice." Although initial licensure for graduates of preventive medicine residency training programs has not historically been a problem, difficulties often arise when physicians practicing in nonclinical settings seek to renew their license in a state where active clinical practice is required for license renewal. A similar problem has been documented in cases in which physicians working in nonclinical settings move to a new state that requires demonstration of active clinical practice for licensure.

Historical Background

In 2008, the American College of Preventive Medicine (ACPM), the national medical specialty society for preventive medicine physicians, was informed of a number of specific cases in which preventive medicine physicians faced difficulties obtaining a state medical license. The cases stemmed from individual state definitions of "medical practice," which sometimes included a direct clinical patient care requirement. These anecdotal reports to ACPM fell into two broad categories. The first affected primarily board-certified preventive medicine physicians who were licensed in one or more states and then moved to another state in which they applied for a license. When such an application was made in a state whose definition of "medical practice" required a direct clinical care component, these credentialed physicians were either initially denied a license or were required to document clinical competency through a variety of recognized means. In many cases, the delay in licensure took 1 year or more.

The second type of report involved residents who were new graduates of programs that traditionally may not have had a clear clinical component for the entire 3 years of training. Prior to adoption of new training requirements by the preventive medicine community and the Accreditation Council on Graduate Medical Education (ACGME) that strengthened the clinical competencies of preventive medicine residency training programs, some states may have questioned the clinical training component of a preventive medicine residency. These new graduates in the specialty reported difficulty or delay in receiving a license, and in some cases, denial of a license.

During the time since these initial reports were received, the issue of preserving the ability of preventive medicine physicians to obtain and maintain an unrestricted medical license in all 50 states has become a priority issue for ACPM. The issue is of professional importance to preventive medicine physicians because they often are required to have a medical license as a condition of employment in nonclinical positions. In addition, they must have a current medical license to become and remain board-certified in preventive medicine.

In response to these reports, Neal Kohatsu, chair of the ACPM Graduate Medical Education (GME) Committee, in consultation with then-president of ACPM Michael Parkinson, established the Physician Licensure Task Force in order to define the scope of this issue for preventive medicine physicians and recommend appropriate action. A town hall meeting at the *Preventive Medicine 2009* annual conference was organized to collect information from physicians who had been affected by this issue. In 2010, ACPM was alerted by the North Carolina Academy of Preventive Medicine that the state was considering a "second-tier" administrative medical license applicable to the specialty of preventive medicine. ACPM worked with its North Carolina component society to provide formal testimony opposing the creation of such a license and to educate policymakers and others about the practice of population-based medicine as a legitimate "clinical practice of medicine." This collaborative effort on the part of the ACPM resulted in a decision by North Carolina's state medical board to not pursue creation of an administrative license and to retain full medical licensure for North Carolina preventive medicine physicians.

Many other member state medical boards of the Federation of State Medical Boards (FSMB) are considering implementing "maintenance of licensure" programs, which often include requirements related to the "active practice of medicine." In addition, states continue to consider changing physician licensure requirements such that physicians who do not engage in full-time patient care would be relegated to a lower-class license status. These proposed policies would disproportionately affect preventive medicine physicians because they often practice in settings other than those that involve direct patient care.

Table 1. States with statutory or regulatory language suggesting clinical practice requirements for full, unrestricted medical licensure

State	Strict language—requires active practice of clinical medicine for full licensure	Vague language—does not mention "prevention" as demonstrating active practice of medicine
Iowa		X
Kansas		X
Maine	X	
Mississippi	X	
Montana		X
Nebraska		X
New Jersey		X
New Mexico		X
Ohio		X
Oregon	X	
Tennessee (MD and DO)		X
Texas	X	
Utah (MD and DO)		X
Washington state (DO)		X
West Virginia		X

DO, Doctor of Osteopathic Medicine; MD, Medical Doctor

The ACPM Physician Licensure Task Force drafted a summary report that provided an overview of the barriers to medical licensure faced by preventive medicine physicians and included a comprehensive review of state statutes that govern the provision of medical licensure. The summary report identified 15 states that have either strict or vague requirements for the active practice of clinical medicine as part of their licensure requirements (Table 1). In addition, according to the American Medical Association (AMA) publication, "State Medical Licensure Requirements and Statistics, 2012," there are 29 states that have a statutory policy regarding physician re-entry into practice (Table 2).

In most cases, re-entry entails any return to practice after a hiatus from active, direct care of patients in a one-on-one patient care setting. Across the 29 states that have a policy on physician re-entry into practice, the length of time out of practice after which completion of a re-entry program is required ranges from 1 to 5 years (mean 2.9 years). Some states have no specified or variable time periods, and others leave the time period to the board's discretion.

The requirements for remediation or "re-entry" into practice vary from being decided on a case-by-case basis, appearing before the board, competency evaluation, completion of SPEX/COMVEX exams, continuing medical education credits, practice monitoring, additional testing, mentorship, training, or education if deemed necessary.[3] The various state statutes include a number of heterogeneous combinations of practice, time limit, and remediation requirements, which range from very lenient to very strict with the majority falling between these extremes. A few states, however, did have statutory or regulatory language suggesting that "administrative medicine" or "prevent[ion]" activities constitute the active practice of medicine for full, unrestricted medical licensure. These states include Colorado, Florida, Maryland, Nevada, North Carolina, South Carolina, Vermont, and Virginia.

Position Statement of the College

The ACPM is aggressively approaching this vital issue from many avenues in order to best help its members reach a successful resolution. The ACPM Physician Licensure Task Force developed a policy resolution[3] that was successfully ushered through the AMA House of Delegates meeting, an issue brief, letters of support for ACPM members to use with medical boards and other stakeholder organizations, a policy statement for FSMB officials, and a summary report that illustrated the analysis and findings of the task force's efforts. The issue brief has been successfully used by preventive medicine physicians who have experienced difficulties in securing a medical license, and the policy resolution "Licensure for Physicians Not Engaged in Direct Patient Care"[4] is now part of the AMA policy compendium.

The following are the ACPM public policy positions regarding licensure challenges in preventive medicine. Through its members and leadership, the ACPM will:

- Oppose laws, regulations, and policies that would limit the ability of a physician to obtain or renew an unrestricted state or territorial medical license based solely on the fact that the physician is engaged exclusively in medical practice that does not include direct patient care.
- Oppose activities by medical licensure boards to create separate categories of medical licensure solely on the basis of the predominant professional activity of the practicing physician.

Table 2. States with policies regarding "re-entry" into medical practice that may affect preventive medicine physician licensure[3]

State	Length of time out of practice (years)	Case-by-case or board discretion
Arizona (MD and DO)		X
Arkansas	Unspecified	
California (DO)	5	
Colorado	2	
Connecticut	2	
Florida (MD and DO)	4 (for DO)	X (for MD)
Georgia		X
Illinois	3	
Iowa	3	
Kansas	2	
Kentucky	2	
Maryland	5	
Minnesota	3	X
Mississippi	3	
Montana	2	
Nebraska	2 of the previous 3	
Nevada (MD and DO)	1 (for MD)	
Unspecified (for DO)		
New Jersey	5	X
New Mexico	2	
North Carolina	2	
Ohio	2	
Oregon	2, may differ by specialty	
Pennsylvania	4	
South Carolina	4	
Tennessee (MD and DO)	5 (for MD)	X (for MD and DO)
Utah (MD and DO)	5	
Vermont (MD and DO)	3 (for MD) 1 (for DO)	
Virginia	4	
Washington state (MD)	2, may differ by specialty	

DO, Doctor of Osteopathic Medicine; MD, Medical Doctor

- Urge constituent state and territorial medical societies to advocate to their respective medical boards the establishment of policies that will facilitate provision and renewal of unrestricted state or territorial medical licenses to physicians in medical practice that does not include direct patient care.
- Advocate that the FSMB support provision of unrestricted state or territorial medical licenses to physicians engaged in the practice of population-based medicine.
- Advocate the development of uniform state licensure policies that recognize the key influence of all ACGME-accredited residency graduates in academic, research, governmental, and physician leadership positions while including public and population health in definitions of the "active practice of medicine."
- Participate as a resource and a stakeholder in discussions relating to these issues.

Conclusion

Preventive medicine is a unique medical specialty by virtue of the training its practitioners undergo in the population-based approach to healthcare delivery and the predominance within the specialty of physicians who often practice in settings that do not include direct patient care. Physicians with these credentials in population medicine are essential for public safety and for assurance of the quality of healthcare services; they are particularly in demand in the current era of accountable care. Despite the unique benefits that preventive medicine physicians bring to bear on the healthcare marketplace, they often hit barriers when seeking to renew a medical license or obtain a new license when they relocate.

To help address this continued problem, uniform state licensure policies must be developed that include the practice of population-based medicine in state definitions of "active medical practice." As our healthcare system continues to evolve toward the practice of population-based medicine through identification of population-level outcomes and quality measures, it is imperative that state definitions of "active medical practice" value and support the work of physicians who practice in settings outside of direct patient care. ACPM will continue to advocate for the development of uniform state licensure policies and work with colleagues from the American College of Physician Executives, the Association of American Medical College's Council of Deans, the American College of Medical Quality, and others who may be adversely affected by these important issues relating to state medical licensure.

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