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Review Article

Do preventive medicine physicians practice medicine?

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ABSTRACT

As some preventive medicine physicians have been denied medical licenses for not engaging in direct patient care, this paper attempts to answer the question, “Do preventive medicine physicians practice medicine?” by exploring the requirements of licensure, the definition of “practice” in the context of modern medicine, and by comparing the specialty of preventive medicine to other specialties which should invite similar scrutiny. The authors could find no explicit licensure requirement for either a certain amount of time in patient care or a number of patients seen. No physicians board certified in Public Health and General Preventive Medicine sit on any state medical boards. The authors propose that state medical boards accept a broad standard of medical practice, which includes the practice of preventive medicine specialists, for licensing purposes.

1. Introduction

Do preventive medicine physicians practice medicine? State medical boards have essentially posed this question when deciding whether to grant or renew licenses for preventive medicine specialists. Some boards have apparently concluded that preventive medicine specialists are not practicing physicians, unless they participate in direct clinical patient care activities, resulting in denied licenses (Hull et al., 2013).

The authors believe this conclusion is erroneous and short-sighted. Specifically, the authors believe that such decisions result from misunderstanding the specialty of preventive medicine, misinterpretation of licensure requirements, failure to consider modern medical practice and the lack of preventive medicine physicians on medical licensing boards.

The purpose of this paper is to provide a framework through which the preventive medicine specialty can counter policies requiring “direct patient care” for licensure.

2. Licensure, certification, and privileging

The purpose of medical licensure is “to protect the public from the unprofessional, improper, incompetent, unlawful, fraudulent and deceptive practice of medicine” (Chaudhry et al., 2013).

To be licensed, a physician must, at a minimum, graduate from an accredited medical school, complete a certain amount of graduate medical education in an accredited program (usually 1 year), obtain successful scores on a licensing exam, and adhere to professional standards and professional bearing (typically evidenced by the absence of a significant criminal record or ethical violations, and, in most states, acquiring a minimum number of continuing medical education credits each year).

Licensure is a prerequisite for both board certification and privileging. Board certification demonstrates “that a physician meets nationally recognized standards for education, knowledge, experience, and skills and maintains their certification through continuous learning and practice improvement in order to provide high quality care in a specific medical specialty or subspecialty” (American Board of Medical Specialties, n.d.). Privileging determines which clinical services, based on a physician's credentials and experience, may be performed at a given facility (Hunt, 2012). In other words, a physician with a license alone would not be expected or allowed to perform complicated surgical procedures anywhere and in any situation; board certification and privileging are designed to regulate these aspects of practice.

Licensure therefore sets the minimum requirements for medical practice in a given jurisdiction – in essence, the lowest common denominator. And licensing requirements vary significantly. For example, some states explicitly define “prevention” as patient care while others do not (Hull et al., 2013). Some state licensing boards do not require any continuing education to maintain licensure, while others require dozens of hours each year, with some hours spent on specific topics such as HIV/AIDS (Federation of State Medical Boards, n.d.).

The relationship between licensure, board certification, and privileging is complex and not unidirectional. Each is its own unique credential. However, as licensure is the lowest common denominator (without a license, board certification and privileges are meaningless), state medical boards should apply standards for licensure to all

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physicians consistently.

3. How unique is preventive medicine?

The authors' review of publicly available information from 65 state medical boards (50 states and Washington, D.C., and 14 osteopathic boards) revealed no specific information requiring 'direct patient care' for licensure or any requirements specifying an exact number of hours spent in patient care or number of patients seen, suggesting that a decision to deny licensure may result from a combination of misinterpretation of statutes or regulations and a misunderstanding of the specialty of preventive medicine.

Preventive medicine is a bona fide medical specialty with practitioners trained in clinical medicine and population health. The essence of preventive medicine is training and practice in public health (Jung and Lushniak, 2017). To assume that the entire specialty of preventive medicine, by definition, precludes direct patient care is fallacious, as many preventive medicine specialists have thriving practices involving direct patient care. But consider the quintessential preventive medicine specialist, working as a state or local health official, toiling in obscurity to hold contagions at bay, increasing opportunities for citizens to maintain and improve their health, elevating the health of the population. Is this preventive medicine specialist practicing medicine? Perhaps patients may not understand the impact of preventive medicine physicians on their health simply because there is no direct contact. Compare this example with the pathologist examining biopsies on glass slides or the radiologist reading films against a lightbox. Are they practicing medicine?

For pathologists, "consultation with a patient is a rare event" and "the doctor-patient relationship…precludes a direct pathologist-patient relationship" (Gutmann, 2003). In fact, pathologists have "little need, incentive or opportunity to speak with patients" (Gutmann, 2003).

Radiologists themselves debate whether they are "real doctors," (McLarson, n.d.; Future Proof, 2016) and the majority of patients don't believe radiologists are physicians at all (Miller et al., n.d.). Even if they are "real doctors," one sentiment opines, "We are radiologists after all. Very few of us chose radiology initially because we enjoyed rounding on patients" (Funaki, 2006).

Given published comments openly questioning whether these other recognized medical specialties engage in direct patient care, it is fair to ask if radiologists and pathologists regularly encounter licensing bodies demanding direct patient care for licensure (the authors found no published evidence of either radiologists or pathologists encountering such difficulty solely because of their specialty).

Perhaps there is a more direct explanation for this treatment of preventive medicine specialists: of the 486 physicians sitting on 65 state medical boards, only two are board certified by the American Board of Preventive Medicine, one in Clinical Informatics and one in Occupational Medicine. No physicians board certified in Public Health and General Preventive Medicine currently sit on any state medical boards (Table 1).

Outside of those cases reported in the medical literature (Hull et al., 2013), the authors are unaware of any additional cases of state medical boards denying preventive medicine specialists a license. But the magnitude of the problem is not in the numbers of physicians affected, but rather in the existential issue for both the preventive medicine specialty and for those physicians in other specialties who do not engage in direct patient care.

Consider the surgeon who ascends to become Dean of a medical school and no longer has time to perform surgery. The psychiatrist who becomes a county health director and no longer sees patients in clinical practice but implements a mental health program for the county. The geriatrician elected to the U.S. Senate and is prohibited by ethics regulations to work in a clinical setting that serves Medicare recipients. The cardiologist who believes so strongly in prevention that he devotes the entirety of his practice to nutrition counseling classes and prescribing exercise. Would any of the physicians in these examples be "practicing medicine"?

4. Quantity or quality of direct patient care?

If a physician meets a direct patient care requirement for licensure, should there be any consideration of the quantity or quality of care provided? In the authors' review of licensure requirements, state medical boards do not appear to specify requirements for either a quantity or quality of direct patient care, raising the question of exactly how much direct patient care is adequate, not to mention whether the quality of care is an issue.

Does 16 h of direct patient care per week qualify a physician more than 4 h per week? Is 4 h of "high quality" care per week better than 16 h of "low quality" care? State licensing bodies that merely require unqualified "direct patient care" have stepped onto a slippery slope that ignores the rigorous requirements of certification and privileging.

There are some published data on the decay rate of medical skills that supports a scientific determination of what quantity of direct patient care is necessary over a period of time for a physician to maintain their clinical competence (Lammers et al., 2008). But medical licensure requirements do not appear to be based on these data. Health systems and facilities presumably make such determinations utilizing the privileging process. And specialty boards establish the criteria by which physician competency should be evaluated for their specialty. Established mechanisms to define competency and currency in a bona fide medical specialty should be sufficient to establish providers certified through that mechanism as legitimate medical practitioners. And licensure, along with board certification and privileging, should avoid unnecessary duplication and onerous administrative burdens.

5. Modern medical practice

Medical licensing bodies may be operating on an outdated assumption of medical practice, where physicians attend to a singular patient. Modern medical practice in 2018 is much broader in scope than this narrow definition, having moved far beyond the basic notion of individual care, and state licensing requirements have not kept pace. Modern physicians cannot simply "see patients."

5.1. The Triple Aim

The Institute for Healthcare Improvement developed the Triple Aim, a framework for optimizing health system performance defined as "improving the individual experience of care; improving the health of populations; and reducing the per capita costs of care for populations" (Berwick et al., 2008). Two of these three aims will not be achieved through direct patient care alone. Modern practitioners must be cognizant of these aims, as well as how they and their practices can contribute to them.

The Triple Aim also promotes an "integrator" responsible for all three aims for a given population (Berwick et al., 2008). Preventive medicine physicians are ideal practitioners for work within the integrator, which is critical to patient health.

5.2. Public Health 3.0

Public Health 3.0, a federal initiative to upgrade public health efforts, recommends a Chief Public Health Strategist for communities to ensure health considerations in planning and policy (Public Health 3.0, n.d.). Just like the Triple Aim's "integrator" the Chief Public Health Strategist is a natural fit for a preventive medicine physician (Jung and Lushniak, 2017). Although direct patient care is part of both the Triple Aim and Public Health 3.0, physicians working in other aspects of these initiatives must be considered just as, if not more, important to patient health.

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