

What surgeons should know about...

Medical licensure and state regulation of medical practice

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The practice of medicine is highly regulated at both the federal and state levels. Medicare and Medicaid regulations, public health rules, certificate of need laws, and insurance mandates are just some of the more obvious examples of the regulatory and administrative complexities that influence modern medical practice. One area that may not always receive the same degree of attention, though, is that of medical licensure.

Physicians must be licensed to practice medicine in the state in which they provide medical care. After undergoing a rigorous initial process to gain a license, however, many physicians give little thought to their licensure status until it is time to renew. In most states, license renewal is on a two- or three-year cycle. For most physicians, renewing a license involves payment of the renewal fee, submission of evidence of completion of continuing medical education (CME) requirements, and maintenance of acceptable standards of professional conduct and medical practice. This article addresses some of the licensure-related issues about which surgeons should stay informed.

How is physician licensure regulated?

States regulate physicians through a medical practice act. They generally limit licensure in these acts to medical doctors or doctors of osteopathy. The medical practice act adopted by the state legislature grants regulatory authority to a medical board, which may be called a medical licensing board, a board of medical examiners, or a board of medicine. The act typically contains provisions that define the practice of medicine and requirements for licensure (education, training, and so on); describe various license categories, such as temporary or special licenses; specify individuals who may be appointed to the board and the process for selecting them; explain

what constitutes a violation of the act and the practice of medicine, as well as how the board may discipline a physician for a violation; and indicate how to deal with impaired physicians. The Federation of State Medical Boards (FSMB) provides guidance to state medical boards on elements of medical practice acts and regularly updates the Essentials of a Modern Medical Practice Act, which may be accessed at http://www.fsmb.org/grpol_policydocs.html.

Licensure and disciplinary activities may be carried out by two separate boards. For instance, Illinois has a medical licensing board and a medical disciplinary board. The Illinois Department of Financial and Professional Regulation oversees both boards and is responsible for licensure of approximately 1 million professionals in more than 100 industries in the state. As this example demonstrates, professional licensure is a major component of state regulatory functions.

There are 70 medical boards in the U.S. and its territories, including 14 state boards of osteopathic medicine. At one time, most states had separate osteopathic boards, but over the years, many of these have been combined with medical boards. Ultimately, these boards are charged with protecting the public from the unprofessional, improper, unlawful, or incompetent practice of medicine.

How many CME credits are necessary to renew a medical license?

The number of CME credit hours per year required for renewal of a medical license varies from state to state. Some states require a specific number of hours in a particular subject, such as pain management, human immunodeficiency virus and acquired immune deficiency syndrome, child abuse, domestic violence, or palliative care. A few states have no CME requirements for license renewal, including Colorado, Indiana,

Montana, New York, Oregon, South Dakota, and Vermont, as well as Hawaii's osteopathy board.

The American Medical Association provides a list of hours per renewal cycle by state on its Web site. To view this information, visit <http://www.ama-assn.org/ama/pub/category/2640.html>.

The medical boards have a major role in disciplining physicians. What types of actions may they take against a physician's license and when is disciplinary action permissible?

As noted in the Essentials of a Modern Medical Practice Act, state medical boards may take a range of disciplinary actions against a physician, including revoking or suspending a license; placing a licensee on probation; putting stipulations, limitations, restrictions, and conditions relating to practice on the license; censuring, reprimanding, or chastising the physician; seeking monetary redress to another party or a period of free public or charity service, either medical or nonmedical; compelling the physician to satisfactorily complete an educational, training, and/or treatment program; and leveling a fine or charge to cover disciplinary costs.

The Essentials provides a long list of what defines unprofessional or dishonorable conduct subject to disciplinary action. Examples of some more egregious violations include the following:

- Fraud or misrepresentation in applying for or procuring a medical license
- The commission or conviction of a gross misdemeanor or a felony, regardless of whether the crime is related to the practice of medicine, or the entry of a guilty or nolo contendere plea to a gross misdemeanor or a felony charge
- Conduct likely to deceive, defraud, or harm the public
- Disruptive behavior and/or interaction with physicians, hospital personnel, patients, family members, or others that interferes with patient care or could reasonably be expected to adversely affect the quality of care rendered to a patient
- Negligence in the practice of medicine as determined by the board
- Being mentally or physically unable to engage safely in the practice of medicine
- Commission of any act of sexual misconduct,

including sexual contact with patient surrogates or key third parties, which exploits the physician-patient relationship in a sexual way

- Habitual or excessive use or abuse of drugs, alcohol, or other substances that impair ability

How can medical boards fulfill their responsibility and protect the public from incompetent physicians?

Generally speaking, the licensure process is designed to ensure the competent and ethical practice of medicine. Certainly, the vast majority of physicians provide this type of care. However, medical boards are continually examining ways to improve in this area. At the 2006 annual meeting of the FSMB, a number of sessions centered on maintenance of certification, measurement of performance and quality, and implementation of physician health programs. Speakers included representatives from the American Board of Medical Specialties, the American Medical Association Physician Consortium for Performance Improvement, and the National Board of Medical Examiners.

The FSMB also launched a competency initiative in 2005 called the Physician Accountability for Physician Competence. Since then, stakeholders have been participating in a number of competency summits, and an update on this initiative likely will be presented at the 2007 annual meeting of the federation. The focus of this effort is to address how the medical profession will self-regulate in the future, and what role medical boards will have in ensuring the ongoing competence of physicians.

What can medical boards do to address the expansion of scope of practice for nonphysicians?

Many states have gone through legislative battles related to nonphysicians expanding their scope of practice into areas traditionally handled by physicians and osteopathic physicians. Typically, state legislatures have addressed this issue through amendments to the definition of non-physician scope of practice within their respective practice acts.

In addition, the respective boards may try

to reach some sort of resolution. Allied health professionals have their own regulatory boards (such as a state board of nursing or of optometry), and most medical boards have no authority over what those boards do. They may request to meet with the other boards, or, in some instances, the boards may form joint committees boards to address a specific issue.

The medical board can go to the legislature and ask for a statutory solution as well. If all else fails, lawsuits can be filed by one board against another to delay or stop implementation of an expansion of scope of practice.

Medical boards are responsible for defining the practice of medicine and may pursue legal options against individuals who practice medicine without a license. Most often, these cases involve individuals who claim to be physicians but are not.

The FSMB adopted a policy document in 2005—Assessing Scope of Practice in Health Care Delivery: Critical Questions in Assuring Public Access and Safety—which is available at http://www.fsmb.org/grpol_policydocs.html. This informational guide outlines patient safety and quality of care issues health care regulatory boards and legislative bodies should consider when making decisions about changes in scope of practice and when attempting to bypass established regulatory standards to extend health care services to underserved areas.

What are some of the “hot” topics currently being considered by medical boards?

Physician volunteers and national emergencies: One of the more immediate concerns during the relief effort for victims of Hurricane Katrina was provision of medical care. Unfortunately, it was difficult for physicians to just show up and volunteer their services because of licensing and liability issues; for example, because the licensing board computers were water damaged, it was impossible to verify credentials. Since then, medical boards have been grappling with questions about out-of-state licensure of medical professionals who volunteer their services during natural or manmade disasters. One suggestion has been to issue a national license, which has received little attention within the state medi-

cal board community. The FSMB has a national credentials verification service that can help during an emergency, provided the medical board in the state experiencing the emergency can access the service.

If not currently involved, state medical boards will need to start working with the federal government on this issue. Before adjourning in December 2006, the 109th Congress adopted the Pandemic and All-Hazards Preparedness Act. One section of this legislation codifies the existing Volunteer Medical Reserve Corps and ensures a coordinated national infrastructure for deploying volunteers to respond to national emergencies. The legislation also requires the federal government to link existing state volunteer verification systems and maintain a single, nationwide, interoperable network of systems for the purpose of advance registration of volunteer health professions. This system verifies credentials, licenses, and certifications to enable rapid response to public health emergencies.

Specialty licensure: Specialty licensure has been debated for many years. Currently, physicians are licensed to practice medicine in whatever specialty they choose and are not prevented through licensure from practicing outside of their specialty training. In light of the concerns related to physician competence, greater interest has been expressed in the concept of specialty licensure.

Telehealth/telemedicine: As technology has advanced, telehealth and telemedicine have increased in importance. Not only are there licensure issues across state lines, but national boundaries also come into play when, for example, computed tomography scans can be read by a physician in another country with a report e-mailed to a physician in the U.S. for a patient visit the next day. Improvements in robotic surgery also create cross-border licensure challenges. One potential solution recommended by the FSMB and its Special Committee on License Portability is an expedited licensure process by endorsement if physicians meet a number of qualifications, including the following:

1. Full and unrestricted licensure (in all jurisdictions where a medical license is held)
2. Free of disciplinary history, license restric-

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tions, or pending investigations (in all jurisdictions where a medical license is or has been held)

3. Graduation from an approved medical school or current Educational Commission for Foreign Medical Graduates (ECFMG) certification

4. Passage of a licensing examination acceptable for initial licensure within three attempts per step/level and within a seven-year period

5. Completion of three years of progressive postgraduate training in an accredited program

6. Current certification from a medical specialty board recognized by the American Board of Medical Specialties or the American Osteopathic Association; lifetime certificate holders who have not passed a written specialty recertification examination must demonstrate successful completion of the Special Purpose Examination, Comprehensive Osteopathic Medical Variable Purpose Examination, or applicable recertification examination.

Where can surgeons obtain licensure information?

State medical boards have their own Web pages, and the quickest way to obtain licensure information, notice of proposed medical licensure rules, or other items is through those sites. Some sites even permit license renewal online. The FSMB provides links to each state medical board at *http://www.fsmb.org/directory_smb.html*.

In addition to monitoring state legislation and working with ACS chapters and Fellows on advocacy initiatives pertaining to state legislation, the College's State Affairs staff has expanded its focus into medical licensure regulation. Chapters or surgeons are welcome to notify the College of proposed regulations or other licensure issues at State_Affairs@facs.org. 