REENTRY TO PRACTICE

Report of the FSMB Workgroup on Reentry to Practice
Draft, January 2024

Executive Summary

Physicians may take a leave from practice for a variety of reasons, necessitating reentry. The following document contains guidance for state medical boards when considering potential reentry to practice requirements for physicians seeking to regain licensure following a significant absence from practice. Recommendations offered in the document reflect an appreciation that unique situations exist for physicians (and includes physician assistants) seeking to reenter practice and therefore we encourage flexibility and the need to consider reentry decisions on a case-by-case basis.

Key considerations for state medical boards in reentry decisions include:

- the duration of time out of practice;
- clinical and other relevant activities engaged in by the physician while out of practice;
- the need for assessment of a physician's competence prior to reentry to practice;
- reentry during public health emergencies;
- collection of data about the clinical activity of the licensee population;
- the variety of challenges faced by physicians seeking to reenter practice;
- instances where absence from practice occurs to manage potentially impairing illness;
- differing reentry requirements where absence from practice occurs as a result of state medical board disciplinary proceedings or criminal conviction;
- mentoring and supervision for reentering physicians; and
- differing requirements when retraining is required due to a change in scope of practice or a lack of training or experience in the physician's intended scope of practice.

The following recommendations are included for state medical boards:

1) State medical boards should proactively communicate with and educate licensees/applicants about the issues associated with reentering clinical practice.
2) Reentry to practice decisions should be made on a case-by-case basis.
3) All licensees/applicants returning to clinical practice after a period of inactivity should be required to provide a detailed description of their future scope of practice plans.
4) State medical boards and licensees/applicants who have been clinically inactive should agree upon a reentry to practice plan acceptable to the state medical board. Applicants should provide proof of completion of the plan prior to reentry.
5) State medical boards should foster collaborative relationships with academic institutions, community hospital training centers, state medical societies, and state chapters of specialty societies to develop and ensure the availability of assessment, educational and other interventions and resources for the various types of practices.
6) Supervisory arrangements for reentering physicians should be approved by state medical boards. Where formal supervision is not required, mentorship may be arranged by

reentering physicians. State medical boards should make efforts to ensure a sufficient pool of supervisors and mentors is available to reentering physicians.

7) State medical boards should require licensees to report information about their practice as part of the license renewal process, including type of practice, status, whether they are actively seeing patients, specialty board certification status, and what activities they are engaged in if they are not engaged in clinical practice.
8) Licensees who are clinically inactive should be allowed to maintain their licensure status provided they meet the requirements set forth by the state medical board. Depending on a licensee's engagement in activities designed to maintain clinical competence, should the licensee choose to return to active clinical practice, the board may require participation in a reentry program.
9) State medical boards should be consistent in the creation and execution of reentry programs.

Introduction

In April 2012, the Federation of State Medical Boards (FSMB) adopted the *Report of the Special Committee on Reentry to Practice (2012).* The following year, the FSMB adopted the *Report of the Special Committee on Reentry for the Ill Physician (2013).* At the time of their adoption, the two reports addressed current regulatory challenges associated with physician reentry to practice, while recognizing that there was a paucity of research surrounding the issue. Despite minimal advance in research, widespread recognition has since developed that physicians may take a temporary absence from clinical practice for a variety of reasons, and physician reentry can be a common part of a physician's continuing practice of medicine.

Jeffrey D. Carter, MD, Chair of the FSMB, appointed the Workgroup on Reentry to Practice in May 2023 to update and bring current FSMB policies related to reentry to practice for state medical and osteopathic boards (hereinafter referred to as "state medical boards" and/or "medical boards"). The Workgroup was charged with conducting a comprehensive review of state medical and osteopathic board rules, regulations and policies related to reentry to practice; conducting a review and evaluation of FSMB policies, including *Reentry to Practice (HOD 2012)* and *Reentry for the Ill Physician (HOD 2013)* and specifically the recommendations regarding out of practice timelines based on current evidence; conducting a literature review of related research, guidelines and other publications and the impact of demographic changes in the physician workforce on licensure and practice; identifying available educational resources and activities for physicians to positively impact their ability to demonstrate their fitness to reenter the workforce; and identifying options for competency assessment tools for state medical boards to evaluate physicians' fitness to reenter the workforce.

In meeting its charge, the Workgroup also surveyed medical boards to better understand the current priorities and procedures related to the departure and reentry to practice. Survey results indicated that reentry to practice is a high priority for medical boards. Results also indicated that 57 percent of responding medical boards ask licensees, whether during license renewal or another mechanism, if they are actively clinically practicing. However, a greater number of medical boards (69 percent of respondents) reported not collecting data on the number of medical professionals who left clinical practice and applied for reentry.

The results of the survey helped guide Workgroup discussions, as did the involvement of a subject matter expert with extensive experience working in assessment and training of physicians reentering practice. These also helped inform the Workgroup's decision that *Reentry to Practice* and *Reentry for the Ill Physician* should be combined into one document, as did FSMB's recent experience working with state medical boards on the issue of physician well-being. This report, and recommendations, are intended to serve as a framework for common reentry standards and processes. These recommendations are also intended to provide flexibility for state medical boards and physician and physician assistant licensees/applicants.

The recommendations provided in this report are organized as follows:

- Education and Communication
- Determining Medical Fitness to Reenter Practice
- Supervision and Mentoring for Practitioners Who Want to Reenter the Workforce

- Improving Regulation of Licensed Practitioners Who are Clinically Inactive

Section One. Glossary

The Workgroup presents the following glossary to support a common interpretation of key terms related to reentry to practice.

"Absence from Practice" means any duration of time that a physician voluntarily takes an absence from providing direct, consultative, or supervisory patient care. Some absences from practice may require a medical board-approved reentry process, whereas absences of shorter duration or absences that include activities aimed at maintaining competence may not. Unless otherwise specified, an absence from practice does not include absences that result from medical board disciplinary action.

"Clinically Active Practice" means a physician who, at the time of license renewal, is engaged in direct, consultative, or supervisory patient care, or as further defined by the states.

"Mentoring" means a dynamic, reciprocal relationship in a work environment between two individuals where, often but not always, one is an experienced physician in active practice and the other is a physician reentering practice. The peer-relationship is aimed at providing the physician reentering practice with knowledge and resources to support safe reentry. This relationship is distinct from a supervisory relationship in that the mentor plays a supportive role but does not have a specific reporting responsibility to the medical board beyond that which would exist in any clinical context.

"Physician Reentry" means a return to clinical practice in the discipline in which one has been trained or certified following an extended period of clinical inactivity not resulting from medical board disciplinary action. Physician reentry is distinct from remediation or retraining.

"Physician Reentry Program" means a formal, structured curriculum and clinical experience which prepares a physician to return to clinical practice following an extended period of clinical inactivity.

"Physician Retraining" means the process of learning the necessary skills to move into a new clinical area that is distinct from the area of one's primary medical training. Physician retraining is distinct from physician reentry.

"Supervision" means a medical board-mandated process whereby a supervisor physician, who has been actively practicing for at least the five prior consecutive years, observes a physician reentering practice for a defined period and provides feedback, educational, and clinical support. The support is aimed at ensuring safe reentry to practice. This relationship is distinct from a mentor relationship in that the supervisor has a defined responsibility to the medical board for assessing the reentering physician's fitness to practice independently. For physician assistants, the role of supervisor may be fulfilled by the supervising physician.

Section Two. Key Issues

The Workgroup identified several key issues relevant to state medical board decisions about reentry to practice.

Timeframe

More than two years away from practice is commonly accepted as the timeframe for when physicians should go through a reentry process. The two-year timeframe is based on extensive state medical board experience and subject matter expertise in physician assessment and remediation. The Workgroup recognizes the need for flexibility when applying the two-years-absent-from-practice timeframe to an individual physician, as there is great variability in specialty, type of practice, and clinical and educational engagement while absent from practice.

When determining whether a physician requires a reentry to practice program, a medical board may choose to consider the following factors:

- administrative or consultative activity (e.g., chart reviews);
- concordance of prior and intended scopes of practice;
- educational or mentoring responsibilities;
- intention to perform procedures upon reentry;
- length of time in practice prior to departure;
- participation in accredited continuing medical education and/or volunteer activities during the time out of practice;
- participation in continuous certification[1] prior to departure from practice;
- prior disciplinary history;
- time since completion of post-graduate training; and
- whether absence from practice resulted from disciplinary action or criminal conviction

Assessment of Fitness to Reenter Practice

It is the responsibility of state medical boards to determine whether a licensee/applicant who has had an absence from practice should demonstrate whether they are competent to reenter practice. The assessment, as well as the assessment modality or modalities may be tailored to the individual. If it is not immediately clear what needs to be assessed as part of the licensee's fitness to practice, state medical boards are encouraged to seek the expertise of assessment organizations with experience in this area.[2] Boards may recommend that clinically inactive physicians proactively complete a self-assessment prior to reentering practice to identify any clinical deficiencies as this may be valuable in determining board-mandated reentry requirements.

Public Health Emergencies

During public health emergencies, state medical boards may recognize the need to, and choose to, implement temporary licensure modifications and waivers allowing clinically inactive physicians to reenter practice. When doing so, medical boards should utilize mechanisms that can quickly identify and verify credentials of health professionals to ensure patient safety and maintain

[1] The Workgroup recognizes that at the time of drafting, some specialty certifying boards continue to use the term "Maintenance of Certification" to describe this process.

[2] FSMB, Directory of Physician Assessment and Remedial Education Programs. October 2023, available at: https://www.fsmb.org/siteassets/spex/pdfs/remedprog.pdf.

oversight of licensure waivers that fall outside medical board control. If a clinically inactive physician chooses to practice beyond the public health emergency, they must complete the appropriate reentry program determined by the state medical board. Boards are encouraged to make licensees aware of Provider Bridge so they may choose to register as potential volunteers in advance of future public health emergencies.

State Medical Board Data Collection on Clinical Activity

State medical boards should consider means of collecting information from licensees about their clinical activity to understand workforce demographics. While some state medical boards will be limited in their capacity to collect data on licensee clinical activity, they may wish to consider alternative means to collecting this on licensing applications such as optional surveys to licensees. This can be particularly important for understanding the degree to which active licensees are not clinically active, and may inform reentry decisions for this population.

Challenges to Reentry

There are difficulties associated with identifying entities that provide reentry services to physicians. These include cost, geographic considerations, eligibility requirements, licensure, malpractice issues and lack of uniformity among alternatives available to physicians seeking reentry. While some of these challenges are outside the purview of state medical boards, others can be mitigated by boards, including requirements for mentors, rather than supervisors, and the ability to obtain a training license. State medical boards may choose to review their current practices to avoid undue burdens or barriers to reentry, while being mindful of patient safety considerations. Boards may proactively choose to communicate these challenges to licensees so that they can plan accordingly when an absence from practice is anticipated.

- *Cost and duration of reentry programs*: Due to the time and resources required to effectively assess and support a physician through a reentry process, reentry programs are, of necessity, costly. However, they are an essential mechanism to inform state medical board decisions about reentry requirements in the interest of patient safety.
- *Accessibility of reentry programs*: There is a wide range of entities[3] that offer reentry services, ranging in remediation programs to mini residencies. Accessibility may vary depending on the needs of the reentering physician and the geographic location of reentry programs. However, as some services are being offered online, accessibility is improving.
- *Availability of mentors and supervisors*: It may be challenging for medical boards to identify and select mentors and supervisors based on the needs of the reentering physician, due to various reasons, including geographical location or specialty. Boards may develop a roster of mentors and supervisors that would serve in these roles for reentering physicians. Recruitment may occur through questions on renewal applications or through advertising in board publications.
- *Ability to obtain a training license (and engage in clinical activity without a full and unrestricted license)*: As many medical board-approved programs necessitate clinical training which includes direct patient care, a training license is required. However, this license type is not offered in all states. Boards may choose to evaluate whether their existing license types include a license that permits reentering physicians to practice within

[3] *Ibid.*

their reentry program. Possible license types may include a limited or special purpose license, temporary license, or a resident license.

- *Medical Liability Insurance and Hospital Credentialing/Privileging*: In many jurisdictions it is not possible to obtain liability insurance without first obtaining a medical license. As mentioned previously, because of this requirement, medical boards may again choose to evaluate whether their existing license types include a license that permits reentering physicians to practice and subsequently obtain liability insurance. It is also not possible to obtain hospital privileges without first obtaining a license or liability insurance.

Impairment

The terms "illness" and "impairment" are not synonymous. Illness is the term used to describe the existence of a disease state. It can be physical or psychiatric and can include addictive disease, injury, and cognitive change. Impairment, however, is a functional classification that implies the inability of the person affected by illness or injury to provide medical care with reasonable skill and safety.[4]

A physician who is or has been ill is not necessarily impaired and may be able to function effectively and practice safely, especially with participation in relevant treatment programs and ongoing monitoring, where appropriate. Therefore, the same set of reentry requirements and programs should be available to this population of physicians seeking reentry. State medical boards may familiarize themselves with the FSMB's *Policy on Physician Illness and Impairment* (HOD, 2021), as well as resources available in their state, such as the state's Physician Health Program.

Mentoring and Supervision of Reentry Physicians

Academic Medical Centers (AMCs) and Community Hospital Training Centers have a role in physician reentry as they already have the facilities, faculty, and resources to effectively perform assessment and training. AMCs and Community Hospital Training Centers can provide a complete reentry package from initial assessment of the reentry physician to final evaluation of competence and performance in practice. AMCs can provide selected services on an as-needed basis such as assessment testing, focused practice-based learning, procedure labs and identifying and vetting mentors and supervisors. Potential incentives to stimulate AMC involvement in reentry include research opportunities and generation of revenue.

Maintaining Licensure if Not in Active Clinical Practice

Some states consider the work done and decisions made by medical directors of health care programs to be the practice of medicine and therefore they are required to have an active license. Other states issue administrative medicine licenses as a distinct area of practice, which includes consultations and other educational functions that are non-clinical in nature. These types of licenses do not include the authority to practice clinical medicine, examine, care for, or treat patients, prescribe medications including controlled substances, or delegate medical acts or prescriptive authority to others.[5]

[4] FSMB, *Policy on Physician Illness and Impairment: Towards a Model that Optimizes Patient Safety and Physician Health*. May 2021, available at: https://www.fsmb.org/siteassets/advocacy/policies/policy-on-physician-impairment.pdf.

[5] Iowa Code Ann. § 148.11A.

Retraining When Practice Differs or is Modified from Area of Primary Training

Some physicians who seek reentry want to practice in a specialty or area that differs from their area of primary training. In such cases, it is considered retraining, not reentry, and would require the physician to complete the necessary educational and training requirements for the new specialty. An obstetrician/gynecologist wishing to practice family medicine would fall into this category and require retraining. A physician seeking to narrow their primary area of practice, however, would not need to complete retraining, such as when an obstetrician/gynecologist wishes to limit their practice to only gynecology.

Section Three. Recommendations

The following recommendations are intended to provide state medical boards, licensees, health insurers, physician health programs, health care organizations, and state government agencies with a framework for developing common standards and terminology around the reentry process.

Education and Communication

Recommendation 1: Proactive communications

To help prepare licensees/applicants who either are thinking about taking a leave of absence or are considering returning to clinical practice, state medical boards should proactively educate licensees/applicants about ways to maintain competence while absent from practice and the issues associated with reentering clinical practice (e.g., continued participation in CME activities while out of practice, unintended consequences of taking a leave of absence such as impact on malpractice costs and future employment). For example, state medical boards could develop written guidance on issues like the importance of engaging in clinical practice, if even on a limited, part-time basis, or seeking counsel from their insurance carriers prior to withdrawal from practice and when they are ready to reenter practice. They might also suggest that the licensee/applicant review the FSMB Roadmap for Those Considering Temporarily Leaving Practice (See Appendix A). State medical boards could include such information with the initial license, with the license renewal application, in the board's newsletter, and on the board's website. This may also help physicians who are contemplating retirement but are unaware that a reentry process may be required by their state medical board if they change their mind.

Determining Medical Fitness to Reenter Practice

Recommendation 2: Review on a case-by-case basis

Because competence is maintained in part through continuous engagement in patient care activities, licensees/applicants seeking to return to clinical work after an absence from practice should be considered on a case- by-case basis. Absences from practice of two years or greater are generally accepted as the minimum timeframe for when physicians should be required to engage in a reentry process. However, decisions about whether the licensee/applicant should demonstrate readiness to reenter practice should be based on a global review of the licensee/applicant's situation, including:

- administrative or consultative activity (e.g., chart reviews);
- concordance of prior and intended scopes of practice;
- educational or mentoring responsibilities;
- intention to perform procedures upon reentry;
- length of time in practice prior to departure;

- participation in accredited continuing medical education and/or volunteer activities during the time out of practice;
- participation in continuous certification prior to departure from practice;
- prior disciplinary history;
- time since completion of post-graduate training; and
- whether absence from practice resulted from disciplinary action or criminal conviction

Licensees/applicants who wish to take some time away from clinical practice should be encouraged to remain clinically active in some, even if limited, capacity, and urged to participate in continuing medical education and continuous certification.

Recommendation 3: Documentation

All licensees/applicants returning to clinical practice after a period of inactivity should be required to provide a detailed description of their future scope of practice plans. The degree of documentation required may vary depending on the length of time away from clinical practice and whether the licensee/applicant's scope of practice is consistent with their medical education and training. For example, documented evidence might include CME certificates and verification of volunteer activities.

A physician returning to a scope or area of practice in which they previously trained or certified, or in which they previously had an extensive work history may need reentry. A physician returning to clinical work in an area or scope of practice in which they have not previously trained or certified or in which they have not had an extensive work history needs retraining and, for the purposes of this report, is not considered a reentry physician. The reentering licensee/applicant should also be required to provide information regarding the environment within which they will be practicing, the types of patients they anticipate seeing, and the types of clinical activities in which they will be engaged.

Recommendation 4: Reentry plan after extended time out of practice

State medical boards and licensees/applicants who have been clinically inactive should agree upon a reentry to practice plan based on various considerations, which may include a self-assessment by the licensee/applicant, assessment of the licensee/applicant's knowledge and skills, and any activities completed during the absence from practice. The state medical board has final approval of the reentry plan and the licensee/applicant should be required to present proof of completion of the plan to the state medical board.

In instances where reentry plans require activities involving direct patient care, state medical boards may consider whether their existing license types allow for the reentering physician to practice. Such licenses permit the licensee/applicant to participate in activities necessary to regain the knowledge and skills needed to provide safe patient care, such as participation in a mini residency.

Recommendation 5: State medical board collaborative relationships

State medical boards should foster collaborative relationships with academic institutions, community hospital training centers, state medical societies, and state chapters of specialty societies to develop assessment, educational and other interventions and resources for the various

types of practices. The National Board of Osteopathic Medical Examiners, the National Board of Medical Examiners, the American Board of Medical Specialties, the American Osteopathic Association Bureau of Osteopathic Specialties, and the American Medical Association may likewise serve in a supportive role to state medical boards in this regard. These institutions and organizations may have readily adaptable programs or simulation centers that meet the individual needs of reentering physicians.

Supervision and Mentoring for Practitioners Who Want to Reenter the Workforce

Recommendation 6: State medical board-approved supervisors and mentors

Supervisors may be selected by either the state medical board or the licensee/applicant, but in all cases should be approved by the state medical board. At a minimum, the supervisor should be ABMS or AOA board certified, have no prior disciplinary history, and practice in the same clinical area as the licensee/applicant seeking reentry.

The state medical board should set forth in writing its expectations of the supervisor, including what aspects of the reentering licensee/applicant's practice are to be supervised, frequency and content of reports by the supervisor to the state medical board, and how long the practice is to be supervised. The board's expectations should be communicated both to the supervisor and the licensee/applicant being supervised. For physician assistants, the role of supervisor may be fulfilled by the supervising physician.

The supervisor should be required to demonstrate to the medical board's satisfaction that they have the capacity to serve as a supervisor, for example, sufficient time for supervising, lack of disciplinary history, proof of an active, unrestricted medical license, and demonstration of having actively practiced for at least the prior five consecutive years. The supervisor may be permitted to receive financial compensation or incentives for work associated with supervision. Potential sources of bias should be identified, and in some cases may disqualify a potential supervisor from acting in that capacity.

The licensee/applicant reentering practice should establish a peer-mentorship with an actively practicing physician who meets the requirements of a supervising physician, but the mentor does not require medical board approval or reporting beyond that which would typically exist in any clinical context.

State medical boards should work with state medical and osteopathic societies and associations and the medical education community to identify and increase the pool of potential supervisors and mentors. To protect the pool of supervisors, boards may make supervisors agents of the board.

Improving Regulation of Licensed Practitioners Who are Clinically Inactive

Recommendation 7: Identifying clinically inactive licensees

State medical boards should require licensees to report information about their practice as part of the license renewal process, including type of practice, status (e.g., full-time, part-time, number of hours worked per week), whether they are actively seeing patients, specialty board certification status, and what activities they are engaged in if they are not engaged in clinical practice (e.g., research, administration, non-medical work, retired, etc.). Such information will enable state medical boards to identify licensees who are not clinically active and to intervene and guide, as

needed, if a licensee chooses to return to patient care duties. State medical boards should advise licensees who are clinically inactive of their responsibility to participate in an individualized, diagnostic reentry plan prior to resuming patient care duties.

Recommendation 8: Licensure status

Licensees who are clinically inactive should be allowed to maintain their licensure status if they pay the required fees and complete any required continuing medical education or other requirements as set forth by the medical board. Depending on a licensee's engagement in activities designed to maintain clinical competence, should the licensee choose to return to active clinical practice, the board may require participation in a reentry program.

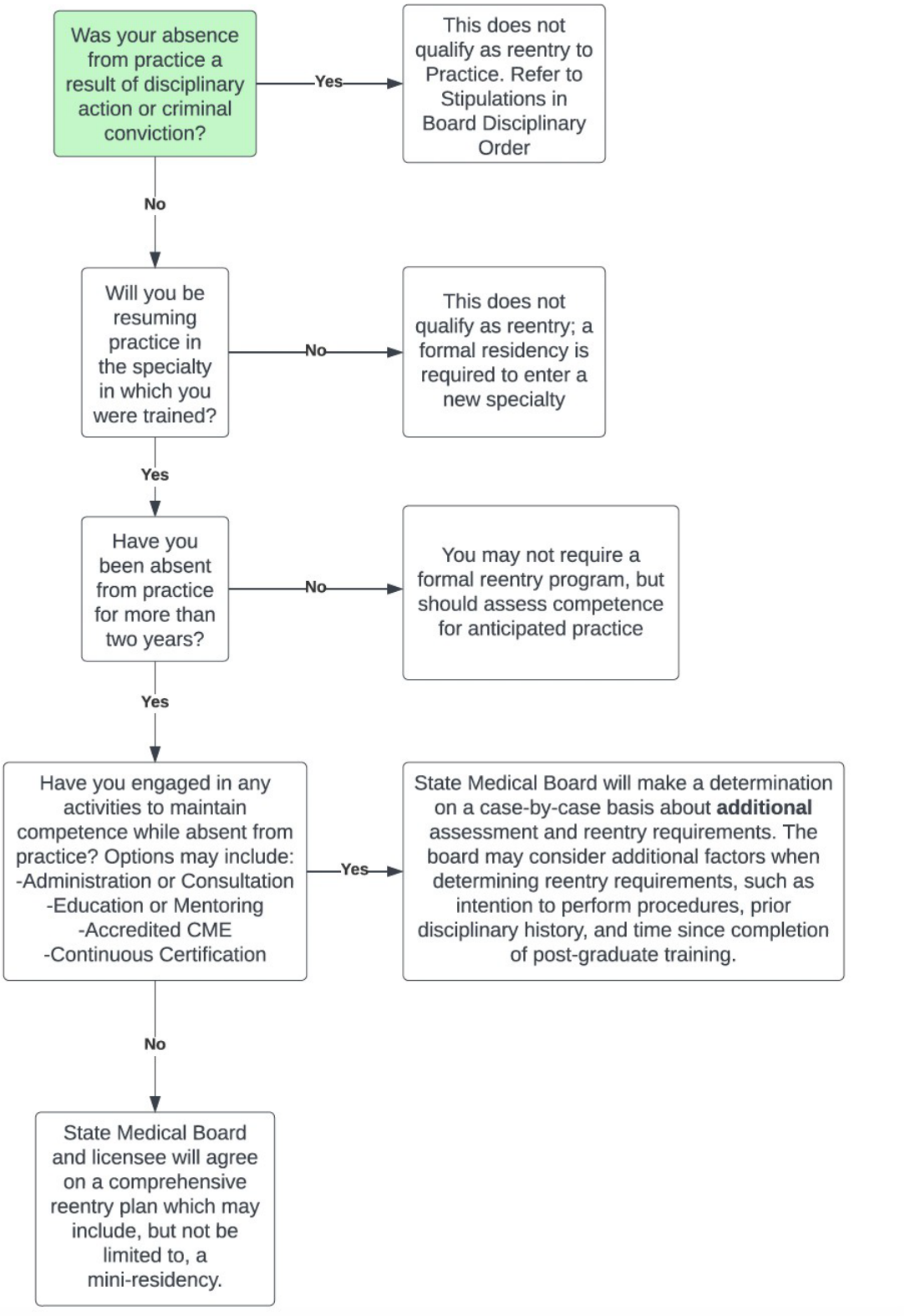
Recommendation 9: Consistency of reentry across jurisdictions

State medical boards should be consistent in the creation and execution of reentry programs. In recognition of the differences in resources, statutes, and operations across states, and acknowledging that implementation of physician reentry should be within the discretion and purview of each board, these guidelines are designed to be flexible to meet local considerations. However, physicians may reasonably be concerned about an overly burdensome reentry process where they might have to meet varying criteria to obtain licensure in different states. For purposes of license portability, FSMB will continue to track the implementation of these guidelines to facilitate transparency for licensees and encourage consistency among boards.

Conclusion

Since the FSMB's *Reentry to Practice (2012),* there has been widespread recognition that physicians may take a temporary absence from clinical practice for a variety of reasons, and physician reentry can be a normal part of a physician's continuing practice of medicine. State medical boards should create standardized processes for reentry to practice that allow flexibility for the board and for the licensee/applicant, while also ensuring patient safety. In creating reentry programs, state medical boards should rely on, and collaborate with, the broader medical system for education, training, and supervision and mentorship.

Appendix A. FSMB Roadmap for Those Considering Temporarily Leaving Practice



Appendix B. Additional policy resources related to physician health, illness and impairment, and physician reentry to practice

1. AMA: Resources for physicians returning to clinical practice, definition of physician impairment, Resources for Physician Health
2. AOA: Resources for Physician Wellness
3. CMSS/Specialty Society: CMSS Position on Physician Reentry (11/11)
4. FSPHP: Public Policy Statement : Physician Illness vs. Impairment
5. ACOG: Re-entering the Practice of Obstetrics and Gynecology

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