Physician Reentry into Clinical Practice: Regulatory Challenges

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ABSTRACT: Physician reentry to clinical practice is fast becoming recognized as an issue of central importance in discussions about the physician workforce. While there are few empirical studies, existing data show that increasing numbers of physicians take a leave of absence from practice at some point during their careers; this trend is expected to continue. The process of returning to clinical practice is coming under scrutiny due to the public's increasing demand for transparency regarding physician competence. Criteria for medical licensure often do not include an expectation of ongoing clinical activity. Physicians who maintain a license but do not practice for a period of time, therefore, may be reentering the workforce with unknown competency to practice. This paper: (1) presents survey data on current physician reentry policies of state medical boards; (2) discusses the findings from the survey within the context of regulatory challenges that impact physician-reentry; and (3) offers recommendations to facilitate the development of comprehensive, coordinated regulatory policies on physician reentry.

Keywords: physician reentry, state medical and osteopathic boards, regulation, physician reentry policy, competence, licensure, workforce

Introduction

Physician reentry is defined by the American Medical Association as: "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 discipline or impairment."[1] Reentering physicians leave clinical practice voluntarily and as such are distinct from remediating physicians, who have demonstrated deficiencies in physician performance. Further, reentering physicians return to the field of practice which they left and, thus, are different from physicians who are retraining in order to move into a new area of clinical practice.[1] Physician reentry is a concept that may be poorly understood by many practitioners.

A number of factors are driving a new emphasis on lifelong evidence of physician competence and assessment of performance in medical practice. Consumer groups such as the American Association of Retired Persons (AARP) and the Citizens Advocacy Center (CAC) — as well as the medical profession itself — have called for tying re-licensure to evidence that physicians possess the requisite knowledge and skills to practice. Both undergraduate and graduate medical education is increasingly structured around the demonstration of a series of competencies. Maintenance of Certification (MOC) and the newly proposed Maintenance of Licensure (MOL) are reflections of this emphasis on continuous competency assessment.

Currently, all of these activities are directed at physicians who are actively practicing medicine. However, regulators recognize that physicians who have been away from clinical practice and seek to return must be included as well. In this new environment of increased focus on physician competence and assessment of

performance, physicians returning to clinical practice after a hiatus pose unique challenges for state medical licensing boards, whose primary objective is public protection.[2]

As the new focus on competence assessment continues to develop, state boards will need to shape systems that effectively address the performance of both practicing physicians and those who wish to reenter medicine after an extended absence. As a starting point in this process, a better understanding is needed of how state boards currently address physician reentry.

This paper addresses that need by (1) presenting survey data on current physician reentry polices of state medical licensing boards; (2) discussing the findings from the survey within the context of physician reentry regulatory challenges; and (3) offering recommendations to facilitate the development of comprehensive, coordinated regulatory policies on physician reentry.

Background

The careers of today's physicians look markedly different from those of previous generations. The belief that successful physicians must sacrifice personal lives for their profession is giving way to an unprecedented desire by both male and female physicians for a work-life balance.[3] Physicians may expect to take time away from practice at some point during their careers for reasons that include family leave (maternity/paternity leave, child rearing); caretaking and personal-relationships issues; health issues; career dissatisfaction; pursuit of alternate careers, such as administration or military service; and humanitarian leave.[4–7]

IN THIS NEW ENVIRONMENT OF INCREASED FOCUS ON PHYSICIAN COMPETENCE AND ASSESSMENT OF PERFORMANCE, PHYSICIANS RETURNING TO CLINICAL PRACTICE AFTER A HIATUS POSE UNIQUE CHALLENGES FOR STATE MEDICAL LICENSING BOARDS.

Physicians may seek reentry to clinical practice for a variety of reasons. Often they return when their need to care for family is no longer pressing or when they have overcome a health issue. Some physicians return because they miss the practice of medicine, have financial needs, want a new challenge, wish to help fulfill community needs or simply have too much free time.[7]

There is little data on whether physicians who return to clinical practice undergo assessment of their knowledge, skills and training and/or education before returning to patient care activities. One study found, however, that among 107 reentering pediatricians, 79 percent did not undergo training before returning to care for patients.[5,8] While more studies are needed on, for example, the relationship between time away from practice and the need for training prior to reentry, the ability of physicians to move in and out of practice without oversight by state medical licensing boards is a limitation of the current medical regulatory process.

The status of a physician's medical licensure is a key factor in the reentry process. Physicians with an active license have more options, as most are not required by medical boards to disclose their clinical activity during the licensure renewal process. One study found only about one-third of medical licensing boards (N = 64) asked physicians about their "clinical activity status both at initial licensure and at renewal."[9] According to the authors of the study, the majority of boards in the United States "allow physicians to hold and renew an unrestricted active license to practice medicine, although they may not have cared for a patient in years."[9] However, the options of physicians without an active license are much more limited. To return to practice, they must contact their state medical licensing board, which will direct their steps toward reentry. The lack of regulatory precedent for reentering physicians, including licensure and credentialing requirements, is a major challenge for state medical licensing boards and, ultimately, for physicians without an active medical license.[10]

Despite the flexibility afforded physicians with active medical licenses, successful return to clinical practice can be a difficult journey. Lack of consistency across jurisdictions in regulatory requirements, including licensure, is a significant barrier. The growing importance of physician reentry as a workforce issue means that state medical licensing boards will increasingly need to address competency and patient safety for physicians in active practice, and for physicians who do not actively provide patient care throughout their careers, as well. Boards will need to do this in the midst of increasing calls for transparency in the regulatory process.

In response, regulatory bodies are moving away from requiring physicians to demonstrate sufficient knowledge and skills at just one point in time, and are beginning to embrace the concept of requiring assessment as part of relicensure — a process known as Maintenance of Licensure (MOL).[11] The Federation of State Medical Boards (FSMB) has been working on a process for MOL since 2003, including conducting a study on the role of state medical boards in ensuring continued competence among physicians and the development of recommendations for use by state medical boards. The FSMB defines MOL as "the process by which a licensee demonstrates that he/she has maintained his or her competence and qualifications for purposes of continued licensure."[12]

The three components of MOL are: (1) reflective self assessment; (2) assessment of knowledge and skills; and (3) performance in practice.[11–12] Of particular relevance to physician reentry is component 3, performance in practice, which states that "physicians must demonstrate accountability for performance in their practice using a variety of methods that incorporate reference data to assess their performance in practice and guide improvement."[12] This component of the proposed framework for MOL indicates that physicians must have ongoing involvement in patient care — a difficult, if not impossible, requirement for reentering physicians.

AS THE NEW FOCUS ON COMPETENCE ASSESSMENT CONTINUES TO DEVELOP, STATE BOARDS WILL NEED TO SHAPE SYSTEMS THAT EFFECTIVELY ADDRESS THE PERFORMANCE OF BOTH PRACTICING PHYSICIANS AND THOSE WHO WISH TO REENTER MEDICINE.

State medical licensing boards have a responsibility to assure the public that physicians possess the requisite knowledge and skills to practice medicine and, thus, will likely have the authority to establish MOL requirements.[12]

State medical licensure requirements and statistics: data on physician reentry into practice

The AMA annually publishes the *State Medical Licensure Requirements and Statistics*, which is based on a survey that includes questions on physician reentry policy. The most recent survey was sent to 64 State Boards of Allopathic and Osteopathic Medical Examiners in the U.S.; medical boards in U.S. territories were excluded. Fifty-nine of the 64 medical boards responded to the survey, for a response rate of 92 percent.

A summary of the aggregate findings in the 2010 survey for the questions related to physician reentry is presented here. The findings represent a "snapshot" of specific physician reentry-related regulations and procedures among these medical boards.

Physician reentry policy

The survey asked "Does your board have a policy on physician reentry (as defined by the AMA) for physicians who have left the active practice of medicine and want to reenter practice?" Thirty (51 percent) of the responding medical boards agreed that they have a policy on physician reentry. Of the 29 medical boards without a physician reentry policy, 16 (55 percent) are either currently developing or planning to develop a policy. Put another way, out of the 59 medical boards in this sample, 78 percent have, are developing, or are planning to develop a policy on physician reentry.

Length of time out of practice

The 30 medical boards with a physician reentry policy were asked "What is the length of time out of practice after which your board requires reentering physicians to complete a reentry program?" Among the 25 medical boards that responded to the question, the average length of time was 2.8 years and ranged from 1 to 10 years. The modal (most common) response was 2 years.

Patient care requirements for relicensure

All of the medical boards were asked "Does your board require a physician to engage in a certain amount of patient care for relicensure?" The vast majority of medical boards (92 percent) do not.

Data collection on reentry

Medical boards were asked "Are you keeping records on the number of physicians the board considered for reentry?" Most (90 percent) medical boards are not collecting this information.

Among the six that do keep records on the number of physicians considered for reentry, five were allopathic boards and five had reentry policies. One board that did not have a reentry policy is keeping records and plans to develop a policy.

Discussion

Approximately three quarters of state medical licensing boards who responded to the survey either have a reentry policy or are in the process of developing or planning to develop one. This is an indication of the growing importance of physician reentry within medicine and the recognition by boards of medicine of the need to address the issue. Boards of medicine seem to be developing physician reentry policies and processes independent of one another; the scope and direction of these policies remain unclear. An unintended consequence of a lack of consistency among state medical licensing boards may be increased difficulty for physicians to reenter clinical practice, particularly if physicians have moved from one state to another during their time away from practice or are participating in reentry programs in a state other than their own.

There is little comprehensive information about the decay rate of specific areas of knowledge and skill. Thus, a physician's need to update his or her knowledge, skills and practice prior to reentry is not clearly defined. This is important information for medical licensing boards as they address policies concerning reentry. The assumption that a physician who has been away from clinical practice needs to update his or her knowledge and skills may be particularly true for medical specialties that rely heavily on technology. It is important to note, however, that while this makes sense intuitively, no studies have been conducted to test this assumption across specialties and practice areas.

Further, studies are needed that would help determine the cut-off point after which a physician's knowledge and/or skills in a particular area deteriorate. Our findings show that on average, medical boards require reentering physicians to participate in education and training (in the form of a physician reentry program) after they have been away from practice for close to three years. However, leading medical organizations such as the FSMB and the American Board of Medical Specialties (ABMS), have recommended a two-year time limit.[13–14] The fact that the time after which a physician should be mandated to participate in a formal reentry process — 1 to 10 years — varies so widely perhaps best illustrates the difficulty state medical boards are experiencing when making this determination without adequate evidence.

Literature intended to inform the decisions by medical licensing boards of when reentering physicians should receive additional education and training may add further confusion. Findings from a study of the relationship between the volume of procedures practiced by physicians and medical outcomes show that the less a procedure is practiced, the greater the likelihood of complication.[15] In a systematic review of the medical literature to study the relationship between experience in caring for patients and performance quality, it was concluded that physicians who have been in practice longer have less factual knowledge then their less-experienced counterparts even after adjusting for patient volume.[16]

The explanation for the results of the latter study, however, may, in fact, have implications for reentering physicians who are also in need of updating their knowledge and skills. With changes in technology and an increase in the volume of medical information, there is a growing need for regulation to assess competency so that patient safety and quality of care are ensured.[11,16–17] Access to current medical knowledge, including changing technologies, must be factored into physician reentry policies that address education and training.

While not all physicians may need to update their skills before reentering practice, the current structure of the licensure system may be preventing medical regulatory bodies from making that assessment. Studies are needed on how time spent away from clinical practice affects the clinical skills of physicians and, ultimately, the quality of care. In addition to guiding state medical boards, these data could potentially be used to develop and refine reentry program curricula and assessment methods.

THE BELIEF THAT SUCCESSFUL PHYSICIANS MUST SACRIFICE PERSONAL LIVES FOR THEIR PROFESSION IS GIVING WAY TO AN UNPRECEDENTED DESIRE BY BOTH MALE AND FEMALE PHYSICIANS FOR A WORK-LIFE BALANCE.

States vary in their definition and criteria for maintaining an active medical license. According to our findings, most (92 percent) state medical boards do not require a specified amount of patient care for relicensure. To date, this has allowed physicians who take a hiatus from clinical practice to maintain an active license.

MOL, if implemented, will present challenges, but also opportunities, for the physician reentry

process. The new requirement could lead to better data collection on physician engagement in practice, including data on physicians who do not actively participate in patient care. Our findings show that the majority (90 percent) of medical boards are not collecting information on physician reentry. It is anticipated that there will be an influx of reentering physicians who will come to the attention of boards of medicine if, for example, "performance in practice" is implemented. The new requirement will change the trajectory to reentry for physicians who have maintained active licenses as they will now have to be accountable to medical boards.

BOARDS OF MEDICINE SEEM TO BE DEVELOPING PHYSICIAN REENTRY POLICIES AND PROCESSES INDEPENDENT OF ONE ANOTHER; THE SCOPE AND DIRECTION OF THESE POLICIES REMAINS UNCLEAR.

The licensure renewal process could include data collection of the number of patient hours physicians spend providing clinical care to patients. Physicians who have been out of clinical practice, but who have maintained licenses, may not be able to resume practice without first demonstrating outcomes from clinical practice as part of MOL component 3, performance in practice. This may place reentering physicians at a disadvantage, particularly if they have been out of practice for a significant period of time. An unintended consequence of "performance in practice" requirements may be that reentry physicians are at risk of losing their active license.

Increased visibility of physicians desiring and achieving reentry is an opportunity for medical licensing boards to collect much-needed information to gain a better understanding of the physician reentry population as a whole. A clearer understanding of these physicians will benefit medical boards in developing reentry policies that result in the return of physicians who provide competent care to patients.

In sum, medical boards face many challenges to developing physician reentry regulatory policies including (1) lack of consistency in state medical licensing laws and regulations; (2) lack of a coordinated database on reentering physicians and physicians needing a reentry process; and (3) issues related to maintenance of licensure, including "performance in practice," for inactive physicians. We offer the following recommendations as a step toward meeting these challenges.

Recommendations for developing regulatory policies on reentry

The recommendations are a product of a 2010 conference titled "Physician Reentry to Clinical Practice: Overcoming Regulatory Challenges Conference," sponsored by the AMA and in collaboration with the FSMB and American Academy of Pediatrics (AAP). The overall goal of these recommendations is to ensure that there is a comprehensive, transparent, and feasible regulatory process that also ensures public safety for use with physicians who desire to return to clinical practice. The recommendations are designed for medical licensing boards to consider as they develop and implement physician reentry policies. For the purposes of this discussion, only the recommendations from the conference pertinent to regulatory issues are included. (The complete set of conference recommendations is available online at http://www.ama-assn.org/resources/doc/med-ed-products/physician-reentry-recommendations.pdf.)

The recommendations suggest that development of a physician reentry regulatory process should be comprehensive and inclusive, involving relevant stakeholder-groups, and it should have the following goals:

1) Develop an understanding of the expectations and needs relevant stakeholder groups — including physicians, patients, regulators, and the public — have for a physician reentry system.

2) Develop physician reentry policy guidelines across state medical licensing jurisdictions that are consistent and evidence-based. These guidelines should clarify:

   - The length of time away from clinical practice which necessitates participating in a reentry process;
   - The definition of how much involvement in clinical care constitutes active clinical practice and the clinical practice requirements for maintaining licensure; and
   - The impact of loss of specialty board certification on maintenance of licensure.

3) Establish mechanisms to permit reentering physicians to engage in clinical practice under supervision as they participate in a reentry program.

These include:

- A site (medical school, graduate medical education program, teaching hospital and medical home, as well as non-traditional sites such as mental health hospitals and nursing homes) that provides reentering physicians with opportunities for supervised clinical practice in their previous clinical fields;
- Hospital credentialing committees allowing reentry program participants to work under supervision; and
- State medical licensing boards establishing a non-disciplinary licensure status option for reentering physicians during their reentry education and training.

4) State medical licensing boards and medical societies should develop a process for a certificate of program completion that meets the need to document physician competency to return to practice.

5) Study the feasibility of introducing alternate licensure tracks for reentering physicians that allow a limited scope of practice.

6) Establish a national physician reentry database to:

- Provide programmatic information to reentering physicians; and
- Track trends in reentry, such as number of reentering physicians, program costs and outcomes.

Addressing the regulatory challenges of physician reentry through a comprehensive process is necessary to demonstrate to the public and to employers that reentering physicians are competent to provide quality care to patients upon their return to clinical practice and to fulfill the high practice standards of the medical profession. To achieve this standard, it will be necessary for physician reentry stakeholders including medical regulators, medical associations, physician reentry programs, researchers and reentry physicians to work collaboratively. The above recommendations, informed by data from state medical boards and input from reentry stakeholders, address physician reentry challenges including the need for increased consistency across state medical boards. These recommendations serve as a mechanism to develop relevant, effective policies to return reentry physicians to providing high-quality care for patients.

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