Physician Reentry

The AMA defines physician reentry 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." Twenty-nine states have specific rules for physicians seeking to reenter clinical practice, such as requiring passage of the Special Purpose Examination (SPEX) (see page 98), and nine states are in the process of developing such policy; others review physicians in this category on a case-by-case basis (Table 20).

The Physician Reentry into the Workforce Project

The issue of physician reentry into the workforce after a period of clinical and/or professional inactivity (not resulting from discipline or impairment) is growing in importance. Anecdotal evidence indicates that reentry into the workforce will affect women more often than men (and the numbers of women entering medical school continue to grow), but this is an issue that cuts across genders and specialties.

To address this growing concern, a number of organizations and individuals are participating in a collaborative endeavor, The Physician Reentry into the Workforce Project, to examine reentry and create guidelines, recommendations, and strategies that will serve to assist physicians and protect patients.

Managed by the American Academy of Pediatrics, Division of Workforce and Medical Education Policy, project participants include representatives of:

- Accreditation Council for Continuing Medical Education
- American Medical Association:
  - Medical Education Group
  - Women Physicians' Congress
- American Academy of Family Physicians
- American Academy of Pediatrics, Committee on Pediatric Education
- American Board of Medical Specialties
- American College of Physicians
- American Osteopathic Association
- Association of American Medical Colleges
- Council on Graduate Medical Education
- Council on Medical Specialty Societies
- Drexel University College of Medicine REMED Program
- Federation of State Medical Boards
- National Board of Medical Examiners
- Naval Medical Center San Diego
- Northeastern Ohio Universities Colleges of Medicine & Pharmacy
- The Joint Commission
- University of California-San Diego Physician Assessment & Clinical Education (PACE) Program

Four topic-specific workgroups have been established to advance the project's agenda:

- Assessment and Evaluation
- Education
- Credentialing, Licensure, and Maintenance of Certification
- Workforce

The Credentialing, Licensure and Maintenance of Certification Workgroup is seeking to identify strategies to help physicians maintain their professional standing while they are absent from the workforce. It will also propose a process for physicians to regain their professional credentials if they lose them and wish to return to active clinical practice. This workgroup's key issues, challenges, and opportunities include:

- Obtaining knowledge regarding the policies of licensing, certifying, and credentialing bodies and staying current with evolving standards and requirements for physicians from various regulatory agencies

- Exploring the need for pertinent regulatory agencies to define reentry policies for their constituents

- Identifying what types of policies regulatory agencies and boards should have regarding how to best communicate their reentry requirements to those licensed in their jurisdiction

- Identifying the challenges for physicians who choose to leave the workforce in the areas of licensure, board certification, and hospital privileges and identifying barriers to reentry that regulatory agencies may impose, even inadvertently.

- Identifying strategies to help physicians maintain their professional standing while they are absent from the physician workforce.

- Identifying current programs that assist physicians in regaining their professional credentials

- Proposing a process for physicians to regain their professional credentials if they lose them and wish to return to clinical practice

- Identifying current programs that assist physicians in regaining their professional credentials

Current members of this workgroup are:

- Carol Clothier, Co-Chair
  Federation of State Medical Boards
- Richard E. Hawkins, MD, Co-Chair
  National Board of Medical Examiners
- Elizabeth A. Bower, MD, MPH
  Oregon Health Sciences University
- Frank Dornfest, MB, ChB, MFGP (SA), FAAFP
  Oregon Health Sciences University
- Sheldon D. Horowitz, MD, FAAP
  American Board of Medical Specialties
- Saralyn Mark, MD, Content Expert
  SolaMed Solutions, LLC
- Lawrence Nazarian, MD, FAAP
  American Academy of Pediatrics,
  Committee on Pediatric Education
- Paul M. Schyve, MD
  The Joint Commission
- Melissa Thomas, MD, PhD
  Laboratory of Molecular Endocrinology,
  Massachusetts General Hospital
- Kelly J. Towey, MEd
  Reentry Project Consultant

Contact information

Physician Reentry into the Workforce Project
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Web site

In addition to serving as a forum for the organizations involved in the project, the Physician Reentry into the Workforce Web site has been enhanced to include resources for individual physicians seeking reentry information.

www.aap.org/reentry

AMA Council on Medical Education Report on Physician Reentry

At its 2008 annual meeting, the AMA House of Delegates adopted as AMA policy the recommendations of AMA Council on Medical Education Report 6, Physician Reentry, asking that the AMA:

1. Continue to collaborate with other appropriate organizations on physician reentry issues including research on the need for and the effectiveness of reentry programs.

2. Work collaboratively with the American Academy of Pediatrics and other interested groups to convene a conference on physician reentry which will bring together key stakeholders to address the development of reentry programs as well as the educational needs of physicians reentering clinical practice.

3. Work with interested parties to establish a physician reentry program information data base that is publicly accessible to physician applicants and which includes information pertaining to program characteristics.

4. Support efforts to ensure the affordability and accessibility, and to address the unique liability issues related to physician reentry programs.

5. Make available to all interested parties the physician reentry program system Guiding Principles for use as a basis for all reentry programs:

a. *Accessible: The reentry program system is accessible by geography, time, and cost.* Reentry programs are available and accessible geographically across the United States and include national and regional pools of reentry positions. Reentering physicians with families or community ties are not burdened by having to relocate to attend a program. The length of time of reentry programs is standardized and is commensurate with the assessed clinical and educational needs of reentering physicians. The cost of reentry programs is not prohibitive to the physician, health care institutions, or the health care system.

b. *Collaborative: The reentry program system is designed to be collaborative to improve communication and resource sharing.* Information and materials including evaluation instruments are shared across specialties, to the extent possible, to improve program and physician performance. A common nomenclature is used to maximize communication across specialties. Reentry programs share resources and create a common repository for such resources, which are easily accessible.

c. *Comprehensive: The reentry program system is comprehensive to maximize program utility.* Physician reentry programs prepare physicians to return to clinical activity in the discipline in which they have been trained or certified and in the practice settings they expect to work including community-based, public health, and hospital-based or academic practice.

d. *Ethical: The reentry program system is based on accepted principles of medical ethics.* Physician reentry programs will conform to physician licensure statues. The standards of professionalism, as stated in the AMA Code of Medical Ethics, must be followed.

e. *Flexible: The reentry program system is flexible in structure in order to maximize program relevancy and usefulness.* Physician reentry programs can accommodate modifications to program requirements and activities in ways that are optimal to the needs of reentering physicians.

f. *Modular: Physician reentry programs are modularized, individualized, and competency-based.* They are tailored to the learning needs of reentering physicians, which prevents the need for large, expensive, and standardized programs. Physicians should only be required to take those modules that allow them to meet an identified educational need.

g. *Innovative: Innovation is built into a reentry program system, allowing programs to offer state of the art learning and meet the diverse and changing needs of reentry physicians.* Physician reentry programs develop and utilize learning tools including experimenting with innovative and novel curricular methodologies such as distance learning technologies and simulation.

h. *Accountable: The reentry program system has mechanisms for assessment and is open to evaluation.* Physician reentry programs have an evaluation component that is comparable among all specialties. Program assessments use objective measures to evaluate physician's competence at time of entry, during the program, and at time of completion. Program outcomes are measured. Reliability and validity of the measures are established. Standardization of measures exist across programs to assess whether or not national standards are being met.

i. *Stable: A funding scheme is in place to ensure the reentry program system is financially stable over the long-term.* Adequate funding allows physician reentry programs to operate at sufficient and appropriate capacity.

j. *Responsive: The reentry program system makes refinements, updates, and other changes when necessary.* Physician reentry programs are equipped to address systemic changes such as changes in regulations. Additionally, the reentry program system is prepared to respond efficiently to urgent health care needs within society including mobilizing clinically inactive physicians temporarily into the workforce to attend to an acute public health crisis, such as a terrorist, biological, chemical, or natural disaster.

6. As part of its Initiative to Transform Medical Education strategic focus and in support of its members and Federation partners, develop model program standards utilizing physician reentry program system Guiding Principles with a report back at the 2009 Interim Meeting.

AMA Initiative to Transform Medical Education (ITME) and Physician Reentry

Since its inception in 2005, the AMA Initiative to Transform Medical Education (ITME) has identified opportunities for improvement in physician education (Phase 1) and developed general recommendations for change across the medical education continuum (Phase 2). A report summarizing Phase 1 and 2 outcomes is available on the AMA Council on Medical Education Web site at *www.ama-assn.org/go/councilmeded*

Currently, ITME is in the third of its three phases, focusing on conducting in-depth research and planning for change in a number of priority areas. In addition to the medical education learning environment, medical school admissions, and physician self-assessment and lifelong learning, ITME's priority list now includes the topic of physician reentry to practice, due to the relative scarcity of and increasing need for reentry programs. To that end, ITME has recommended that the medical education system "consider creating alternatives to the current sequence of the medical education continuum, including introducing options so that physicians can reenter or modify their practices."

Since its inception, ITME has espoused the idea that collaboration and the participation of a wide variety of relevant stakeholders in the health care community is critical to successful outcomes. This is especially true for efforts related to physician reentry. As an example of this collaboration, the AMA and the American Academy of Pediatrics cosponsored the Physician Reentry into the Workforce conference in September 2008, bringing together experts and stakeholders who identified and prioritized plans for future work in four areas:

- Workforce implications
- Regulatory issues, such as licensure
- Assessment and evaluation of competence
- Design and content of reentry programs

Participants generated a variety of suggestions for future data gathering and implementation activities, ranging from developing plans for continuing medical education and career planning activities to disseminating information about existing reentry programs to those who seek to return to the workforce.

Contact Information

AMA Council on Medical Education
515 N State St
Chicago, IL 60654
www.ama-assn.org/go/councilmeded

Table 20
Physician Reentry Regulations

	Board has policy on physician reentry to practice*	Length of time out of practice after which reentry program completion is required	Board developing/ planning to develop policy	Notes
Alabama	No		No	
Alaska	No		Yes	
Arizona	No		No	
Arizona DO	No		Yes	
Arkansas	No		No	
California	No			Board is not permitted to request of a licensee whether the licensee is in active clinical practice. If license is placed in an inactive status, physician must pay fees and complete CME to reactivate; if license canceled, must completely reapply for licensure.
California DO	Yes	5 yrs	—	Must complete a questionnaire provided by Board; submit CME documentation completed within 12 months of reentry, and pay fees. To activate an inactive license, physician must pay fees and complete CME. If license is cancelled, physician must reapply for new license.
Colorado	Yes	2 yrs	—	Personalized competency evaluation report prepared by a Board-approved program, and completion of any education/training recommended by the program as a result of the evaluation. Complete reentry education program upon reactivation or reinstatement or for new applicant.
Connecticut	No			
Delaware	No		No	
DC	No		Yes	Physicians not actively practicing for 1 to 5 yrs must submit proof of 50 Category 1 CME credits for each inactive year. To reactivate a paid inactive license after 5 yrs, either 1 yr of clinical training in an ACGME- or AOA-accredited program or 300 Category 1 CME credits is required.
Florida	Yes	2 yrs for inactive, 5 yrs for retired	—	Physicians with a retired status license who have not practiced in another jurisdiction for 5 or more yrs must pass SPEX; those with an inactive status license who have not practiced in another jurisdiction for 2 of the previous 4 yrs must pass SPEX.
Florida DO	Yes	5 yrs	—	Board recommends Univ. of Florida CARES or CAPS program.
Georgia	Yes	2 yrs	—	If over 2 yrs, a physician must be able to demonstrate current knowledge, skill, and proficiency.
Guam				
Hawaii	No		No	
Hawaii DO				
Idaho	No		No	
Illinois	Yes	2 yrs	—	Detailed information is in Section 1285.95 of the Administrative Rules.
Indiana	No		No	Physicians who let their licenses lapse for more than 3 yrs and are reapplying are reviewed on a case-by-case basis; personal appearance before the Board is required.
Iowa	Yes	3 yrs	—	If physician is applying for a permanent license or reinstating an inactive license to active status and has not practiced within the past 3 yrs in the US/Canada, a competency evaluation is required.
Kansas	Yes	2 yrs	—	Disciplinary plan to adhere to requirements.
Kentucky	No		No	
Louisiana	Yes		—	Applicant would have to meet the requirements for reinstatement or relicensure. Additional information at *www.lsbme.la.gov*.
Maine	Yes	Over 1 yr		Depends on the situation.
Maine DO	No		No	
Maryland	Yes	Case by case	—	Determined on a case-by-case basis. Passing SPEX may be required. A physician whose license has been placed on inactive status or who has failed to renew a license by the 2-month late renewal period and who wishes to practice medicine in Maryland may apply for reinstatement.

(continued on next page)

Table 20 (continued)
Physician Reentry Regulations

	Board has policy on physician reentry to practice*	Length of time out of practice after which reentry program completion is required	Board developing/ planning to develop policy	Notes
Massachusetts	No	Yes		Board requires physician to present a practice plan for reentry to practice if not engaged in direct patient care for more than 2 yrs.
Michigan	No		No	
Michigan DO	No		No	Complete 150 hours of CME with a minimum of 60 hrs in AOA Category 1 activities within immediately previous 3 yrs from date of application.
Minnesota	Yes	2-3 yrs	—	Board reviews on case-by-case basis; generally includes assessment, CME, mentorship, SPEX.
Mississippi	Yes	3 yrs	—	Complete a Board-approved physician assessment or clinical skills assessment program.
Missouri	Yes	2 yrs	—	
Montana	Yes	2 yrs	—	SPEX required if applicant not engaged in the active practice of medicine for 2 or more yrs.
Nebraska	No		—	Board reviews on case-by-case basis.
Nevada	Yes	1 yr	—	Full Board appearance, possibility of peer review or another exam to prove competence.
Nevada DO	Yes		—	Requires proof of CME for all yrs a physician is not licensed with the Board. Inactive status $200 per yr. Additional $200 and proof of CME for inactive yrs required to reactivate practice.
New Hampshire	No		No	No formal policy; decided on case-by-case basis.
New Jersey	Yes	5 yrs	—	
New Mexico	Yes	Over 2 yrs	—	Mini-Sabbatical or participation in CPEP's Clinical Practice Re-Entry Program may be required.
New Mexico DO				
New York	No		No	A licensed physician in inactive status must re-register. If new practice require ments have been enacted, physicians must meet these requirements.
North Carolina	Yes	2 yrs	—	Completion of reentry program required.
North Dakota	No		No	Addressed on case-by-case basis; a reentry plan is developed as appropriate.
Ohio	Yes	2 yrs	—	Board may require an applicant for licensure restoration to pass an exam to determine current fitness to practice. SPEX or Board certification/recertification examination may be required.
Oklahoma	No		Yes	
Oklahoma DO	No			Decided on case-by-case basis.
Oregon	Yes	2 yrs (may differ based on specialty)	—	A physician out of practice more than 12 months may be required to take a competency exam or training.
Pennsylvania	Yes	4 yrs	—	Requirements include CME and, depending on length of time out of practice, reentry to practice plan, including any of the following: successful completion of a clinical skills assessment program, refresher training, mentorship program, a mini-residency, passage of SPEX exam, passage of ABMS board exams, etc.
Pennsylvania DO	No		Yes	Additional training or SPEX may be required, as well as completion of application, proof of CME, and payment of fee.
Puerto Rico				
Rhode Island	No		Yes	Decided on a case-by-case basis and often including specific requirements such as mentorship or CME. Reactivation or reapplication, depending on amount of time lapsed and reason.
South Carolina	No		No	

(continued on next page)

Table 20 (continued)
Physician Reentry Regulations

	Board has policy on physician reentry to practice*	Length of time out of practice after which reentry program completion is required	Board developing/ planning to develop policy	Notes
South Dakota	No		Yes	No formal policy, Board discretion.
Tennessee	Yes	5 yrs	—	Determined on case-by-case basis. Must display clinical competency.
Tennessee DO	Yes	5 yrs	—	Determined on case-by-case basis. Must display clinical competency.
Texas	Yes		—	Board reentry policy does not apply to physicians already licensed who are renewing. Must have been in active practice for one of the 2 yrs preceding the date of application for licensure in Texas.
Utah	Yes	2 yrs	—	SPEX may be required.
Vermont	No	5 yrs	Yes	SPEX may be required.
Vermont DO	Yes	1 yr	—	SPEX may be required.
Virgin Islands				
Virginia	Yes	4 yrs	—	SPEX exam may be required if a physician has not practiced in over 4 yrs.
Washington	Yes	2 yrs	—	SPEX exam, or any other examination deemed appropriate, may be required.
Washington DO	No		No	
West Virginia	No	18 months	No	
West Virginia DO	No		No	
Wisconsin	No	5 yrs	No	After 5 yrs, full reapplication is required; all application questions must be answered and oral examination may be required. If less than 5 yrs, renewal is allowed. Re-registration application is required ($188).
Wyoming	No		Yes	Determined on case-by-case basis; SPEX or other display of clinical competence may be required.
Total (Yes)	**29**		**9**	

* As defined by the AMA

Abbreviations

ACGME—Accreditation Council for Graduate Medical Education

ABMS—American Board of Medical Specialties

AOA—American Osteopathic Association

CME—continuing medical education

CPEP—Center for Personalized Education for Physicians

SPEX—Special Purpose Examination

Note: ***All information should be verified with licensing board; medical licenses are granted to those physicians meeting all state requirements—at the discretion of the board.***