REENTRY TO PRACTICE

Report of the FSMB Workgroup on Reentry to Practice
Adopted by the FSMB House of Delegates, April 2025

Executive Summary

Physicians may take a leave from practice for a variety of reasons that later necessitate reentry. The following document contains guidance for state medical boards when considering potential reentry to practice requirements for physicians seeking to resume active practice following a significant absence. Recommendations offered in the document reflect an appreciation that unique situations sometimes exist for physicians – as well as physician assistants/associates (PAs), for whom many of the policy recommendations in this guidance may also apply[1] – seeking to reenter practice, and flexibility is therefore encouraged, as is the need to consider reentry decisions on a case-by-case basis.

Key considerations for state medical boards in reentry decisions include:

- time out of practice;
- clinical and other relevant activities of 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 licensee clinical activity;
- the variety of challenges faced by physicians seeking to reenter practice;
- instances where absence from practice occurs to manage potentially impairing illness;
- mentoring and supervision for reentering physicians; and
- differing specialty-specific 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 and ways in which the individual may demonstrate engagement in clinically active practice.

[1] Physicians and PAs are held to different standards of practice, reflecting differences in their training, experience, and expertise. Additionally, the degree of practice independence for PAs varies by state, with some requiring physician supervision and others allowing greater autonomy depending on regulatory frameworks.

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 collaborate when developing a reentry to practice plan. 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, medical specialty certifying boards, state medical societies, state physician health programs (PHPs), 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, in collaboration with relevant partners, 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 times 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 advances in research, widespread recognition has occurred that physicians may take a temporary absence from clinical practice for a variety of reasons, and physician reentry can be a common part of any physician's continuing practice of medicine. Organizations such as the American Medical Association (AMA), Federation of State Physician Health Programs (FSPHP), and others have developed policy documents, recommendations and guidelines to assist physicians with addressing these challenges and to explore and clarify the issues surrounding physician illness and its impact (see Appendix B for a list of resources.)

Jeffrey D. Carter, MD, Chair of the FSMB at the time, appointed the Workgroup on Reentry to Practice in May 2023 to update 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 time out of practice, 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 practice; and identifying options for competency assessment tools for state medical boards to evaluate physicians' fitness to reenter practice.

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 licensure 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 (and physician assistants/associates (PAs). 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 its

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 PA licensees/applicants.

The recommendations provided in this report are organized as follows:

- Education and Communication
- Determining Competence 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 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.

"Clinically Active Practice" means engagement in direct, consultative, or supervisory patient care, whether in-person or via telemedicine. Further details and activities, including frequency and intensity of engagement in such activities, may be defined by the state medical board.

"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. Physician reentry is distinct from remediation or retraining.

"Physician Return to Work" means a return to clinical practice after a period of medical leave the duration of which would not be expected to negatively impact practice performance or require reentry interventions. Return to work planning typically occurs under the supervision of a physician health program (PHP).

"Physician Reentry Program" means a formal, structured curriculum, including clinical experience, which prepares a physician to return to clinically active practice following an extended period of clinical inactivity. Physician Reentry Programs follow, and are informed

by, a comprehensive assessment of the physician's competence to determine educational needs.

"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 and may require a new residency.

"Specialty Board Certification" means a process for defining specialty-specific standards for knowledge and skills that includes an independent, external assessment of knowledge and skills for both initial certification and recertification or continuous certification in the medical specialty.[2]

"Supervision" means a medical board-mandated process whereby a supervisor physician, who has ideally been actively practicing for five prior consecutive years, is American Board of Medical Specialties (ABMS) or American Osteopathic Association Bureau of Osteopathic Specialists (AOA BOS) specialty board certified, has no prior disciplinary history during the previous five years and practices in the same clinical area as the licensee/applicant seeking reentry, observes a physician reentering practice for a defined period to provide feedback, education and clinical support aimed at ensuring safe reentry to practice. This relationship is distinct from a mentoring relationship in that the supervisor has a defined responsibility to the medical board for assessing the reentering physician's competence and ability to practice independently. For physician assistants, the role of supervisor may be fulfilled by a supervising physician or a supervising PA who has been actively practicing for at least five consecutive years prior, is National Commission on Certification of Physician Assistants (NCCPA) certified, has no disciplinary history during the last five years, and practices in the same clinical area as the licensee/applicant seeking reentry.

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, however, as there is great variability in specialty, type of practice, and clinical and educational engagement while absent from practice.

[2] American Medical Association, *Medical Specialty Board Certification Standards H-275.926*, 2023, available at: https://policysearch.ama-assn.org/policyfinder/detail/certification?uri=%2FAMADoc%2FHOD.xml-0-1904.xml.

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 during the time out of practice (e.g., chart reviews);
- concordance of prior and intended scopes of practice upon proposed reentry;
- educational, supervisory or mentoring responsibilities during the time out of practice;
- intention to perform procedures upon reentry and types of procedures proposed;
- 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 continuing certification[3] prior to departure from practice;
- prior disciplinary history;
- time since completion of post-graduate training; and
- whether the absence from practice was caused or exacerbated by illness or impairment (with or without board action)

Assessment of Competence 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 how best to assess the licensee's competence, state medical boards are encouraged to seek the expertise of assessment organizations with experience in this area.[4] 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.

Responsibility for assessment may take place through an assessment and remediation program. It may also take place through a formal supervisory relationship. In either case, the party responsible for supervision and assessment should provide ongoing assessment feedback to the reentering physician and updates to the state medical board about the physician's progress. See Appendix C for a sample assessment form that may be shared with the reentering physician and state medical board and can be adapted according to the needs of either party.

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 oversight of any licensure waivers that fall outside

[3] 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.

[4] FSMB, Directory of Physician Assessment and Remedial Education Programs. September 2024, available at: https://www.fsmb.org/siteassets/spex/pdfs/remedprog.pdf.

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,[5] a means by which they may choose to register in advance as potential volunteers for 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. This data should be stratified by race, gender, ethnicity, language and underserved practice areas to understand the equity impact of workforce demographics and determine what is needed to promote an equitable workforce that meets population health needs. 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 collect this information 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 sometimes associated with identifying entities that provide reentry services to physicians. These relate to cost, geographic considerations, eligibility requirements, licensure status, malpractice issues and lack of uniformity among entities 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. This can help avoid possible inequities with certain populations, as well as those in difficult socioeconomic circumstances, that may present additional challenges to accessing reentry processes.

Common challenges to consider may include:

- *Reentry planning for extended absences due to illness or impairment:* When illness or impairment result in an extended absence from practice, medical boards have the additional challenge of considering medical fitness for practice in addition to competence. Board actions related to impairment can also present reentry challenges, especially when the board action (such as license suspension) does not address the additional reentry requirements that may be needed should the physician remain under suspension or restriction for an extended period. Physician health programs (PHPs) are a valuable resource to assist state medical boards with reentry planning when concerns of illness or impairment are present.
- *Cost and duration of reentry programs*: Due to the time and resources often required to effectively assess and support a physician through a reentry process, reentry programs are, of necessity, costly. However, they are an essential

[5] https://www.providerbridge.org/

mechanism to inform state medical board decisions about reentry requirements in the interest of patient safety. State medical boards and others involved in supporting physician reentry should familiarize themselves with their state Vocational Rehabilitation programs which are often able (and required by law) to assist with the costs of reentry programs for physicians.

- *Accessibility of reentry programs*: There is a wide range of entities[6] that offer reentry services, ranging from 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. A need exists for accessible assessments for physician assistants. While options are available through NCCPA's certification and recertification examinations and various other sources, specialty-specific assessment needs remain, particularly in clinical skills and procedure-based assessment.
- *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 wish to develop a roster of mentors and supervisors who could serve in these roles for reentering physicians. Recruitment may be facilitated with 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 that includes direct patient care, a training license may be 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 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 choose to evaluate whether their existing license types include a license that permits reentering physicians to obtain liability insurance required for practice. It is also not possible to obtain hospital privileges without first obtaining a license and liability insurance.

<u>Impairment</u>

Physicians with board action caused or exacerbated by illness or impairment can pose unique challenges for reentry after an extended absence from practice. In addition to this report, state medical boards should familiarize themselves with the FSMB's *Policy on Physician Illness and Impairment* (HOD, 2021) when considering illness and impairment as it presents in the regulatory context.

[6] FSMB, Directory of Physician Assessment and Remedial Education Programs. September 2024, available at: https://www.fsmb.org/siteassets/spex/pdfs/remedprog.pdf.

Ideally, physicians with impairing health conditions will receive appropriate assistance before circumstances necessitate reporting to the state medical board. This is more likely when there are opportunities for physicians to confidentially participate in state physician health programs. When concerns for impairment are reported to the state medical board, it is often possible for the board to refer the matter to the state physician health program without the need for disciplinary action. However, in some cases, impairing illness leads to behaviors or circumstances where discipline is appropriate and necessary. Such disciplinary actions can present unique challenges for return to work and reentry of the ill physician that may not always be anticipated in the disciplinary process. Often, physician health programs are best equipped to help program participants effectively navigate these challenges. As such, the value of state medical board and physician health program collaboration cannot be overstated.

For state medical boards *with* access to a state physician health program, the following are important considerations when an extended absence from practice was caused or exacerbated by illness:

1. State medical boards should weigh endorsement of fitness for practice from the PHP and/or facilitated by the PHP as part of its consideration of a reentry plan when extended practice leave was caused or exacerbated by illness.
2. State medical boards should avoid requiring disclosure of protected health information in developing reentry plans for PHP endorsed physicians.
3. State medical boards should consult with their state physician health program before finalizing orders for PHP-involved physicians. This can help avoid orders that include specific monitoring requirements that might be difficult or impractical for the PHP to implement, impose arbitrary time out of practice that can impede rehabilitation and reentry efforts, or create circumstances that can delay return to work or reentry for physicians who are otherwise fit for practice.
4. License restriction or suspension in cases of impairment may result in extended absences from practice that were not anticipated at the time of the board action. Such orders may stipulate the conditions for reinstatement or termination of restrictions but not include a discernible pathway for reentry when fitness has been restored. State medical boards should consider adding language to orders, in general terms, that address the possibility of additional reentry requirements should there be an extended absence from practice related to board action.

State medical boards that do not have access to a physician health program may have greater difficulty when consideration of illness or impairment is part of reentry planning. Such planning requires careful review of complex and often sensitive health information often pertaining to stigmatized health conditions. The potential for stigma, actual or perceived bias and discrimination in regulatory processes add further complexity to regulatory decisions by state medical boards. Additionally, the possibility of disclosure of medical records to state medical boards as a condition of reentry can undermine trust in the care of the provider-patient relationship. This can result in reluctance to divulge critical health information in the assessment and treatment process, thereby putting the

physician as patient, in addition to that physician's future patients, at increased risk of harm.

For state medical boards *without* access to a state physician health program, the following are important considerations when an extended absence from practice was caused or exacerbated by illness:

1. State medical boards should utilize qualified, board-approved evaluators and treatment providers to determine fitness for reentry when extended practice leave was caused or exacerbated by illness. The *2019 FSPHP Physician Health Program Guidelines* and the *FSPHP Evaluation and Treatment Accreditation™ (FSPHP-ETA™) Standards for Accreditation of Evaluation and Treatment Services for Healthcare Workers in Safety-Sensitive Occupational Roles* can help state medical boards identify and approve qualified evaluators.
2. State medical boards should ensure that physicians with board action related to illness or impairment have decisions about reentry considered on a case-by-case basis. Once fitness to return has been established, these physicians should have access to the same set of reentry requirements, programs and support as other physicians.
3. State medical boards should consider opportunities to reduce the risk of bias and discrimination in situations where they hold potentially stigmatizing health information. Redaction of records, blinding procedures, and case summaries that replace specific diagnoses with general terms such as "health condition" may help mitigate these risks.
4. State medical boards should refer to the FSPHP *2019 Physician Health Program Guidelines* and FSMB *Policy on Physician Illness and Impairment* when there is need to develop an ongoing program of health monitoring as part of a physician reentry plan.
5. State medical boards should critically evaluate their ability to understand and interpret data in mental health, neurocognitive, and substance use disorder evaluation and treatment reports as it pertains to reentry planning. Consultation with physicians who have expertise in mental health, substance use disorders, and/or occupational medicine may be necessary.

<u>Mentoring and Supervision of Reentry Physicians</u>

Academic Medical Centers (AMCs) and Community Hospital Training Centers (CHTCs) have a role in physician reentry as they already have the facilities, faculty, and resources to effectively perform assessment and training. AMCs and CHTCs 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. Acknowledging that assessments for reentry can involve costs that may not be borne solely by the reentering physician, potential incentives to stimulate AMC involvement in reentry include research opportunities and revenue generation.

To help state medical boards evaluate a reentering physician's competence and understand the scope of their reentry program, AMCs and CHTCs should collaborate on the completion of an assessment form. This form could summarize key aspects such as the reentering physician's activities, strengths identified, areas for improvement, a plan for addressing these areas, and any other relevant comments from the assessment (see Appendix C for a suggested template Assessment Form).

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 usually 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.[7]

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 should be considered retraining, not reentry, and would require the physician to complete the necessary educational and training requirements for the new specialty, likely to include a residency. An obstetrician/gynecologist wishing to practice family medicine, for example, would fall into this category and require retraining. A physician seeking to narrow their primary area of practice, such as when an obstetrician/gynecologist wishes to limit their practice to only gynecology, would not necessarily need to complete retraining,

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

State medical boards should have materials that proactively educate licensees/applicants about ways to maintain competence while absent from practice and ways to be considered in clinically active practice. Such materials and education will prepare and inform licensees and applicants who are thinking about taking an extended leave from active practice or are considering returning to clinical practice by:

- clarifying issues associated with reentering clinical practice (e.g., continued participation in CME activities while out of practice); and

[7] Iowa Code Ann. § 148.11A.

- preventing unintended consequences of taking an extended leave from active practice such as impact on specialty certification status, malpractice costs and future employment.

State medical boards could develop written guidance on issues such as 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 Competence 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, supervisory 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 ABMS or AOA BOS continuing board certification prior to departure from practice;
- prior disciplinary history; and
- time since completion of post-graduate training;
- whether the absence from practice was caused or exacerbated by illness or impairment (with or without board action)

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. (See Appendix D for a template reentry plan)

State medical boards should consider consultation or referral to the state physician health program[8] when a health condition may have caused or contributed to time out of practice. The physician health program can provide verification of health and fitness for duty and develop ongoing health support and monitoring when needed to support a reentry.

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 participate in required reentry training programs. 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, established reentry programs, specialty certifying boards, state medical societies, state physician health programs, and state chapters of specialty societies to develop assessment, educational and other interventions and resources for the various types of practices and reentry circumstances. The Accreditation Council for Continuing Medical Education (ACCME), accredited CME community, ABMS, American Medical Association, AOA BOS, National Board of Medical Examiners, National Board of Osteopathic Medical Examiners, National Commission on Certification of Physician Assistants, and FSPHP may likewise serve in a supportive role to state medical boards in this regard. These institutions and organizations may have readily adaptable

[8] A list of state physician health programs is available through the Federation of State Physician Health Programs at the following link: https://www.fsphp.org/state-programs

recommendations and criteria to establish reasonable levels of competence, as well as programs or simulation centers that meet the individual needs of reentering physicians and physician assistants.

With respect to the assessment of physician assistants/associates for reentry purposes, ongoing collaboration with NCCPA on the development of specialty specific resources is recommended.

State physician heath programs often have considerable experience with physician reentry and return to work planning and may be a helpful resource to assist state medical boards develop plans and identify resources to assist with reentry.

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. Ideally, the supervisor should be actively practicing for five prior consecutive years, be ABMS or AOA BOS certified, have no disciplinary history during the previous five years 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 or the supervising PA, who is NCCPA board certified, have no prior disciplinary history during the previous five years, and practice in the same clinical area as the licensee/applicant seeking reentry.

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 active practice for a period as defined by the board. 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.

Separate from a supervisor, the licensee/applicant reentering practice should establish a peer-mentorship with an actively practicing physician who meets the requirements of a supervising physician. The mentor does not require medical board approval, nor would they take on additional mandatory reporting requirements beyond those which would typically exist in any clinical context. In certain circumstances the supervisor and mentor may be the same individual; in those situations, the supervisory requirements supersede the peer-mentorship role.

State medical boards should work with state medical and osteopathic societies and associations and the medical education community, including physician health programs, to identify and increase the pool of potential supervisors and mentors. To protect the pool of supervisors from liability, boards may wish to 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, 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 including continuous participation in ABMS or AOA BOS continuing board certification, 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.

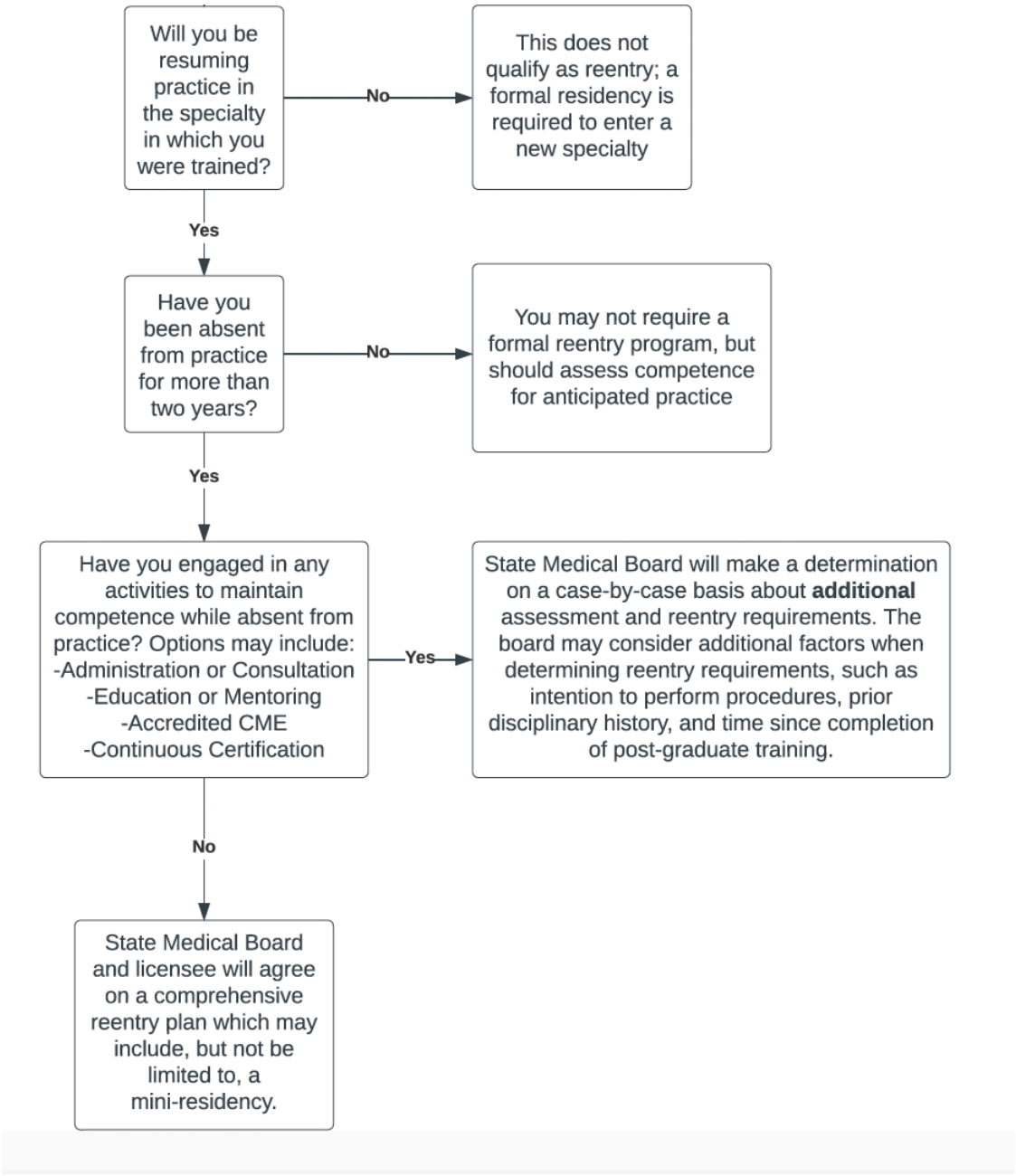
Recommendation 10: Evaluating effectiveness of reentry programs

State medical boards should monitor and evaluate the effectiveness of their reentry programs (i.e. percentage who have successfully completed the process, subsequent complaints and discipline, time in practice following reentry, etc.).

Conclusion

Since the FSMB's *Reentry to Practice (2012),* there has been widespread recognition that physicians may need or want to 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
6. ACCME: Find a CME Provider

Appendix C. Sample Supervision Assessment Feedback Form for Reentry to Practice[9]

Physician Being Evaluated: _____

Date: _____

Supervising Physician/PA: _____

This form is intended to capture feedback provided by a supervisor to a physician or Physician Assistant (PA) who is working to reenter the active practice of medicine. Areas for feedback could be drawn from self-assessment of the reentering physician/PA and direct observation by the supervisor. In completing this form, it may be helpful to structure feedback according to one or more of the Core Competencies of medical practice:

- Medical Knowledge
- Patient Care
- Interpersonal and Communication Skills
- Professionalism
- Systems-Based Practice
- Practice-Based Learning and Improvement

1. Strengths identified:
   _____
   _____
   _____
   _____

2. Areas for improvement:
   _____
   _____
   _____
   _____

3. Agreed interim plan:
   _____
   _____
   _____
   _____

4. Other comments:
   _____
   _____
   _____

[9] Adapted with permission from Texas A&M Rural and Community Health Institute KSTAR Program.

Appendix D. Template Reentry to Practice Plan (To be completed by physician applicant)

Physician Name:
License Number:
Date of Plan:

1. Background Information
    - Date last engaged in active clinical practice:
    - Reason for absence from practice:
    - Brief description of prior clinical practice and specialty/practice area:

2. Assessment of Current Knowledge and Skills
    - Results of formal assessment (if completed):
    - Self-assessment of strengths and areas needing improvement:
    - Plan for addressing any identified gaps:

3. Proposed Scope of Practice Upon Reentry
    - Specialty/practice area:
    - Is this the same as your prior specialty/practice area? (Y/N):
    - Types of procedures to be performed:
    - Patient population:
    - Practice setting:

4. Continuing Medical Education Plan
    - Number and type of CME hours completed in past 2 years:
    - Planned CME activities prior to reentry:

5. Clinical Skills Refresher Activities
    - Observerships/shadowing planned:
    - Simulation training planned:
    - Other clinical skills activities:

6. Supervision Plan
    - Name and credentials of proposed supervisor:
    - Frequency and nature of supervision:
    - Plan for supervisor's reporting to [medical board]:

7. Mentorship Arrangement (if applicable)
    - Name and credentials of proposed mentor:
    - Frequency and nature of mentorship:

8. Timeline
    - Proposed start date for supervised practice:
    - Estimated duration of supervision period:
    - Proposed date for return to practice:

9. Additional Information
    - Malpractice insurance status:
    - Hospital privileges status:
    - Any other relevant information:

Physician/PA Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____

[Medical Board] Approval: _____ Date: _____

FSMB WORKGROUP ON REENTRY TO PRACTICE[10]

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