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**MEDICAL EXAMINING BOARD**  
**Room 121A, 1400 East Washington Avenue, Madison**  
**Contact: Tom Ryan (608) 266-2112**  
**March 21, 2018**

*The following agenda describes the issues that the Board plans to consider at the meeting. At the time of the meeting, items may be removed from the agenda. Please consult the meeting minutes for a record of the actions of the Board.*

**AGENDA**

**8:00 A.M.**

**OPEN SESSION – CALL TO ORDER – ROLL CALL**

- A) Adoption of Agenda (1-5)**
- B) Minutes of February 21, 2018 – Review and Approval (6-12)**
- C) Introductions, Announcements and Recognition**
- D) Conflicts of Interest**
- E) Administrative Matters**
  - 1) Department and Staff Updates
  - 2) Board Members – Term Expiration Dates
    - a) Alaa Abd-Elseyed – 07/01/2020
    - b) David Bryce – 07/01/2021
    - c) Mary Jo Capodice – 07/01/2018
    - d) Michael Carton – 07/01/2020
    - e) Padmaja Doniparthi – 07/01/2021
    - f) Rodney Erickson – 07/01/2019
    - g) Bradley Kudick – 07/01/2020
    - h) Lee Ann Lau – 07/01/2020
    - i) David Roelke – 07/01/2021
    - j) Kenneth Simons – 07/01/2018
    - k) Timothy Westlake – 07/01/2020
    - l) Robert Zoeller – 07/01/2019
    - m) Robert Zondag – 07/01/2018
  - 3) Wis. Stat. § 15.085 (3)(b) – Affiliated Credentialing Boards’ Biannual Meeting with the Medical Examining Board to Consider Matters of Joint Interest
- F) Federation of State Medical Boards (FSMB) Matters**
  - 1) 2018 Annual FSMB Meeting – Resolutions, Reports and Candidate Nominations – Board Discussion (**13-205**)
- G) Re-Entry to Practice (206-362)**

- H) Legislation and Rule Matters – Discussion and Consideration (363)**
  - 1) Scope Statement for Med 13, Relating to Continuing Education (364-365)
  - 2) Scope Statement for Med 20, Relating to Respiratory Care Practitioners (366-367)
  - 3) Update on Legislation and Pending or Possible Rulemaking Projects
- I) Report from Controlled Substances Board – Timothy Westlake**
  - 1) Andrea Magermans – Prescription Drug Monitoring Program (PDMP) Referrals – Discussion and Consideration (368-369)
- J) Interstate Medical Licensure Compact Commission (IMLCC) – Report from Wisconsin’s Commissioners**
- K) Speaking Engagement(s), Travel, or Public Relation Request(s), and Report(s)
- L) Newsletter Matters
- M) Screening Panel Report
- N) Informational Items
- O) Items Added After Preparation of Agenda
  - 1) Introductions, Announcements and Recognition
  - 2) Administrative Updates
  - 3) Elections, Appointments, Reappointments, Confirmations, and Committee, Panel and Liaison Appointments
  - 4) Council Appointment Matters
  - 5) Education and Examination Matters
  - 6) Credentialing Matters
  - 7) Practice Matters
  - 8) Future Agenda Items
  - 9) Legislation/Administrative Rule Matters
  - 10) Liaison Report(s)
  - 11) Newsletter Matters
  - 12) Annual Report Matters
  - 13) Informational Item(s)
  - 14) Disciplinary Matters
  - 15) Presentations of Petition(s) for Summary Suspension
  - 16) Presentation of Proposed Stipulation(s), Final Decision(s) and Order(s)
  - 17) Presentation of Proposed Decisions
  - 18) Presentation of Interim Order(s)
  - 19) Petitions for Re-Hearing
  - 20) Petitions for Assessments
  - 21) Petitions to Vacate Order(s)
  - 22) Petitions for Designation of Hearing Examiner
  - 23) Requests for Disciplinary Proceeding Presentations
  - 24) Motions
  - 25) Petitions
  - 26) Appearances from Requests Received or Renewed
  - 27) Speaking Engagement(s), Travel, or Public Relation Request(s), and Reports
- P) Future Agenda Items
- Q) Public Comments**

**CONVENE TO CLOSED SESSION to deliberate on cases following hearing (§ 19.85 (1) (a), Stats.); to consider licensure or certification of individuals (§ 19.85 (1) (b), Stats.); to consider closing disciplinary investigations with administrative warnings (§ 19.85 (1) (b), Stats. and § 448.02 (8), Stats.); to consider individual histories or disciplinary data (§ 19.85 (1) (f), Stats.); and to confer with legal counsel (§ 19.85 (1) (g), Stats.).**

**R) Credentialing Matters**

**1) Application Review**

a) Ectis Velazquez, M.D. **(370-411)**

**2) Voluntary Surrender Request**

a) David Benzer, D.O. **(412-413)**

**S) Consideration of Waiver of 24 Months of ACGME/AOA Approved Post-Graduate Training**

1) Tatjana Stevanovic, M.D. **(414-462)**

**T) Deliberation on Division of Legal Services and Compliance (DLSC) Matters**

**1) Administrative Warnings**

a) 17 MED 105 **(463-465)**

b) 17 MED 196 **(466-467)**

**2) Case Closings**

a) 16 MED 199 **(468-471)**

b) 16 MED 349 **(472-481)**

c) 16 MED 419 **(482-484)**

d) 16 MED 420 **(485-489)**

e) 16 MED 449 **(490-493)**

f) 17 MED 177 **(494-499)**

g) 17 MED 311 **(500-506)**

h) 17 MED 314 **(507-514)**

i) 17 MED 420 **(515-519)**

**3) Stipulations, Final Decisions and Orders**

a) 14 MED 288 – Anthony G. Conrardy, M.D. **(520-526)**

b) 16 MED 254 – Lori L. Brooks, M.D. **(527-532)**

c) 16 MED 378 – Jose L. Fernandez, M.D. **(533-538)**

d) 17 MED 188 – Vinson M. DiSanto, D.O. **(539-544)**

e) 17 MED 342 – John E. Pappenheim, M.D. **(545-551)**

f) 17 MED 475 – Nancy A. Kressin, M.D. **(552-557)**

**4) Monitoring**

a) Bradley Bourkland, M.D. – Requesting Reinstatement of Full Licensure **(558-614)**

**U) Deliberation on Order Fixing Costs**

1) Larry F. Carlyon, M.D., Respondent (DHA Case Number SPS-17-0023/DLSC Case Number 16 MED 157) **(615-621)**

**V) Open Cases**

**W) Consulting with Legal Counsel**

- X) Deliberation of Items Added After Preparation of the Agenda
  - 1) Education and Examination Matters
  - 2) Credentialing Matters
  - 3) Disciplinary Matters
  - 4) Monitoring Matters
  - 5) Professional Assistance Procedure (PAP) Matters
  - 6) Petition(s) for Summary Suspensions
  - 7) Proposed Stipulations, Final Decisions and Orders
  - 8) Administrative Warnings
  - 9) Proposed Decisions
  - 10) Matters Relating to Costs
  - 11) Complaints
  - 12) Case Closings
  - 13) Case Status Report
  - 14) Petition(s) for Extension of Time
  - 15) Proposed Interim Orders
  - 16) Petitions for Assessments and Evaluations
  - 17) Petitions to Vacate Orders
  - 18) Remedial Education Cases
  - 19) Motions
  - 20) Petitions for Re-Hearing
  - 21) Appearances from Requests Received or Renewed

**RECONVENE TO OPEN SESSION IMMEDIATELY FOLLOWING CLOSED SESSION**

- Y) Open Session Items Noticed Above Not Completed in the Initial Open Session
- Z) **Vote on Items Considered or Deliberated Upon in Closed Session, if Voting is Appropriate**
- AA) **Credentialing Liaison Training**
- BB) **Delegation of Ratification of Examination Results and Ratification of Licenses and Certificates**

**ADJOURNMENT**

**ORAL EXAMINATION OF CANDIDATES FOR LICENSURE**

**ROOM 124D/E**

**10:15 A.M., OR IMMEDIATELY FOLLOWING THE FULL BOARD MEETING**

**CLOSED SESSION** – Reviewing Applications and Conducting Oral Examination of Zero (0) at time of agenda publication) Candidates for Licensure – Dr. Lee Ann Lau and Dr. Kenneth Simons

**NEXT MEETING DATE: APRIL 18, 2018**

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MEETINGS AND HEARINGS ARE OPEN TO THE PUBLIC, AND MAY BE CANCELLED WITHOUT NOTICE.

Times listed for meeting items are approximate and depend on the length of discussion and voting. All meetings are held at 1400 East Washington Avenue, Madison, Wisconsin, unless otherwise noted. In order to confirm a meeting or to request a complete copy of the council's agenda, please call the listed contact person. The council may consider materials or items filed after the transmission of this notice. Interpreters for the hearing impaired provided upon request by contacting the Affirmative Action Officer, 608-266-2112

**MEDICAL EXAMINING BOARD  
MEETING MINUTES  
FEBRUARY 21, 2018**

**PRESENT:** Alaa Abd-Elsayed, M.D.; David Bryce, M.D.; Mary Jo Capodice, D.O.; Michael Carton (*via GoToMeeting*); Padmaja Doniparthi, M.D.; Rodney Erickson, M.D.; Bradley Kudick; Lee Ann Lau, M.D.; David Roelke, M.D.; Kenneth Simons, M.D.; Timothy Westlake, M.D.

**EXCUSED:** Robert Zoeller, M.D.; Robert Zondag

**STAFF:** Tom Ryan, Executive Director; Dale Kleven, Rules Coordinator; Emily Handel, Bureau Assistant; and other Department staff

**CALL TO ORDER**

Kenneth Simons, Chair, called the meeting to order at 8:00 a.m. A quorum of eleven (11) members was confirmed.

**ADOPTION OF AGENDA**

**Amendment to the Agenda**

- Open Session: Under Item “J. Speaking Engagement(s), Travel, or Public Relation Request(s), and Report(s)” **ADD:**
  - “2) Wisconsin Psychiatric Association (WPA) Fall Conference – Speaking Engagement Request – Wisconsin Dells, September 2018
- Closed Session: Under Item “Q. 3) Stipulations, Final Decisions and Orders” **ADD:**
  - 16 MED 025 – Julie R. Fagan, M.D.

**MOTION:** David Roelke moved, seconded by Rodney Erickson, to adopt the agenda as amended. Motion carried unanimously.

**MINUTES OF JANUARY 17, 2018**

**MOTION:** Timothy Westlake moved, seconded by Bradley Kudick, to approve the minutes of January 17, 2018 as published. Motion carried unanimously.

**FEDERATION OF STATE MEDICAL BOARDS MATTERS**

**Re-Designation of Delegate for FSMB Annual Meeting – Board Consideration**

**MOTION:** Rodney Erickson moved, seconded by David Bryce, to designate Mary Jo Capodice, in place of Kenneth Simons, as the Board’s delegate, to attend the 2018 FSMB Annual Meeting on April 26-28, 2018 in Charlotte, North Carolina and to authorize travel. Motion carried unanimously.

**Designation of Mary Jo Capodice to Attend the 2018 American Association of Osteopathic Examiners (AAOE) Annual Business Meeting on April 27, 2018, in conjunction with 2018 FSMB Annual Meeting**

**MOTION:** Lee Ann Lau moved, seconded by Alaa Abd-Elsayed, to designate Mary Jo Capodice to attend the 2018 AAOE Annual Business Meeting on April 27, 2018 in Charlotte, North Carolina. Motion carried unanimously.

**LEGISLATION AND RULE MATTERS**

**Scope Statement for Med 22, Relating to Perfusionists**

**MOTION:** David Roelke moved, seconded by Mary Jo Capodice, to approve the Scope Statement for Med 22, relating to Perfusionists, as revised by adding the phrase “and applicable Wisconsin statutes” to the end of the second paragraph describing the objective of the proposed rule, for submission to the Department of Administration and Governor’s Office and for publication. Additionally, the Board moves to authorize the Chair to approve the scope for implementation no less than 10 days after publication. Motion carried unanimously.

**Update on Legislation and Pending or Possible Rulemaking Projects**

**MOTION:** Lee Ann Lau moved, seconded by Bradley Kudick, to request DSPS staff draft a Scope Statement relating to continuing medical education, and to designate Timothy Westlake to advise DSPS staff. Motion carried unanimously.

**SPEAKING ENGAGEMENT(S), TRAVEL, OR PUBLIC RELATION REQUEST(S) AND REPORT(S)**

**Wisconsin Psychiatric Association (WPA) Fall Conference – Speaking Engagement Request – Wisconsin Dells, September 2018**

**MOTION:** Michael Carton moved, seconded by David Bryce, to authorize Padmaja Doniparthi to speak on behalf of the Board at the WPA Fall Conference in September 2018 in Wisconsin Dells, and to authorize travel. Motion carried unanimously.

## CLOSED SESSION

**MOTION:** Timothy Westlake moved, seconded by Alaa Abd-Elseyed, to convene to Closed Session to deliberate on cases following hearing (§ 19.85 (1) (a), Stats.); to consider licensure or certification of individuals (§ 19.85 (1) (b), Stats.); to consider closing disciplinary investigations with administrative warnings (§ 19.85 (1) (b), Stats. and § 448.02 (8), Stats.); to consider individual histories or disciplinary data (§ 19.85 (1) (f), Stats.); and to confer with legal counsel (§ 19.85 (1) (g), Stats.). Kenneth Simons, Chair, read the language of the motion aloud for the record. The vote of each member was ascertained by voice vote. Roll Call Vote: Alaa Abd-Elseyed-yes; David Bryce-yes; Mary Jo Capodice-yes; Michael Carton-yes; Padmaja Doniparthi-yes; Rodney Erickson-yes; Bradley Kudick-yes; Lee Ann Lau-yes; David Roelke-yes; Kenneth Simons-yes; and Timothy Westlake-yes. Motion carried unanimously.

The Board convened into Closed Session at 9:14 a.m.

## RECONVENE TO OPEN SESSION

**MOTION:** Padmaja Doniparthi moved, seconded by Bradley Kudick, to reconvene to Open Session. Motion carried unanimously.

The Board reconvened to Open Session at 10:27 a.m.

## VOTE ON ITEMS CONSIDERED OR DELIBERATED UPON IN CLOSED SESSION

**MOTION:** Timothy Westlake moved, seconded by Alaa Abd-Elseyed, to affirm all motions made and votes taken in Closed Session. Motion carried unanimously.

*(Be advised that any recusals or abstentions reflected in the closed session motions stand for the purposes of the affirmation vote.)*

## DELIBERATION ON DIVISION OF LEGAL SERVICES AND COMPLIANCE (DLSC) MATTERS

### Complaints

#### **15 MED 093**

**MOTION:** Timothy Westlake moved, seconded by Rodney Erickson, to find probable cause to believe that Arvind Ahuja, M.D., DLSC Case Number 15 MED 093, has committed unprofessional conduct, and therefore to issue the Complaint and hold a hearing on such conduct pursuant to Wis. Stat. § 448.02(3)(b). Motion carried.

*(Lee Ann Lau recused herself and left the room for deliberation and voting in the matter concerning Arvind Ahuja, M.D., DLSC Case Number 15 MED 093.)*

**Administrative Warning**

***17 MED 245***

**MOTION:** Mary Jo Capodice moved, seconded by Bradley Kudick, to issue an Administrative Warning in the matter of DLSC Case Number 17 MED 245. Motion carried unanimously.

***17 MED 387***

**MOTION:** David Roelke moved, seconded by Lee Ann Lau, to issue an Administrative Warning in the matter of DLSC Case Number 17 MED 387. Motion carried unanimously.

**Stipulations, Final Decisions and Orders**

***15 MED 261 & 16 MED 123 – Charles R. Szyman, D.O.***

**MOTION:** Lee Ann Lau moved, seconded by Padmaja Doniparthi, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against Charles R. Szyman, D.O., DLSC Case Number 15 MED 261 & 16 MED 123. Motion carried unanimously.

***16 MED 025 – Julie R. Fagan, M.D.***

**MOTION:** Lee Ann Lau moved, seconded by David Roelke, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against, Julie R. Fagan, M.D., DLSC Case Number 16 MED 025. Motion carried unanimously.

***16 MED 172 – Cristhian Lujan, P.A.***

**MOTION:** David Roelke moved, seconded by Lee Ann Lau, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against, Cristhian Lujan, P.A., DLSC Case Number 16 MED 172. Motion carried unanimously.

**Case Closings**

***15 MED 470***

**MOTION:** Mary Jo Capodice moved, seconded by Bradley Kudick, to close DLSC Case Number 15 MED 470 for No Violation. Motion carried unanimously.

***16 MED 199***

**MOTION:** Mary Jo Capodice moved, seconded by David Bryce, to table DLSC Case Number 16 MED 199. Motion carried unanimously.

**16 MED 202**

**MOTION:** David Bryce moved, seconded by Alaa Abd-Elseyed, to close DLSC Case Number 16 MED 202 for Prosecutorial Discretion (P5-Hold). Motion carried unanimously.

**16 MED 426**

**MOTION:** David Roelke moved, seconded by Bradley Kudick, to close DLSC Case Number 16 MED 426 for Prosecutorial Discretion (P7). Motion carried unanimously.

**16 MED 481**

**MOTION:** Rodney Erickson moved, seconded by Bradley Kudick, to close DLSC Case Number 16 MED 481 for No Violation. Motion carried.

*(Lee Ann Lau recused herself and left the room for deliberation and voting in the matter concerning DLSC Case Number 16 MED 481.)*

**17 MED 191**

**MOTION:** Timothy Westlake moved, seconded by Alaa Abd-Elseyed, to close DLSC Case Number 17 MED 191 for No Violation. Motion carried unanimously.

**17 MED 237**

**MOTION:** David Roelke moved, seconded by Alaa Abd-Elseyed, to close DLSC Case Number 17 MED 237 for Prosecutorial Discretion (P7). Motion carried unanimously.

**17 MED 290**

**MOTION:** Michael Carton moved, seconded by Lee Ann Lau, to close DLSC Case Number 17 MED 290 for No Violation. Motion carried unanimously.

**17 MED 301**

**MOTION:** David Roelke moved, seconded by Lee Ann Lau, to close DLSC Case Number 17 MED 301 for No Violation. Motion carried unanimously.

**17 MED 304**

**MOTION:** Timothy Westlake moved, seconded by Bradley Kudick, to close DLSC Case Number 17 MED 304 for No Violation. Motion carried unanimously.

**17 MED 308**

**MOTION:** David Roelke moved, seconded by Alaa Abd-Elseyed, to close DLSC Case Number 17 MED 308 for No Violation. Motion carried.

*(Kenneth Simons recused himself and left the room for deliberation and voting in the matter concerning DLSC Case Number 17 MED 308. Timothy Westlake, Vice Chair, Chaired the meeting for the deliberation and voting.)*

**17 MED 396**

**MOTION:** David Bryce moved, seconded by Alaa Abd-Elseyed, to close DLSC Case Number 17 MED 396 for Lack of Jurisdiction (L2). Motion carried unanimously.

**Monitoring**

**MICHAEL A. DEHNER, M.D.**

**TERMINATION OF ORDERS #LS0808207MED, #213 AND #2835**

**MOTION:** David Bryce moved, seconded by Lee Ann Lau, to deny the request of Michael A. Dehner, M.D., for return to full unrestricted licensure. **Reason for Denial:** Failure to comply with the terms of ORDERLS0808207MED. Respondent must comply with all the terms of the Order before the Board will consider further modifications. Motion carried unanimously.

**MOTION:** David Roelke moved, seconded by Lee Ann Lau, to grant the request of Michael A. Dehner, M.D., for the termination of ORDER0000213. Motion carried unanimously.

**MOTION:** Rodney Erickson moved, seconded by Bradley Kudick, to deny the request of Michael A. Dehner, M.D., for return to full unrestricted licensure. **Reason for Denial:** Insufficient time under the Board Order (ORDER0002835) to demonstrate adequate compliance. Motion carried unanimously.

**Petition for Extension of Time**

**JOHN KLEMEN, M.D. & ERIC WOHLFEIL, M.D.**

**17 MED 010**

**MOTION:** Bradly Kudick moved, seconded by David Roelke, to grant the Petition for Authorization to Request Extension of Time in the matter of DLSC Case Number 17 MED 010 against John Klemen, M.D. & Eric Wohlfeil, M.D. Motion carried unanimously.

## DELIBERATION ON ORDER FIXING COSTS

### Natasha R. Shallow, M.D., Respondent (DHA Case Number SPS-17-0018/DLSC Case Number 17 MED 159)

**MOTION:** Lee Ann Lau moved, seconded by David Roelke, to adopt the Order Fixing Costs in the matter of disciplinary proceedings against Natasha R. Shallow, M.D., Respondent – DHA Case Number SPS-17-0018/DLSC Case Number 17 MED 159. Motion carried.

*(Mary Jo Capodice recused herself and left the room for deliberation, and voting in the matter concerning Natasha R. Shallow, M.D., Respondent – DHA Case Number SPS-17-0018/DLSC Case Number 17 MED 159.)*

### DELEGATION OF RATIFICATION OF EXAMINATION RESULTS AND RATIFICATION OF LICENSES AND CERTIFICATES

**MOTION:** David Roelke moved, seconded by Timothy Westlake, to delegate ratification of examination results to DSPS staff and to ratify all licenses and certificates as issued. Motion carried unanimously.

### ADJOURNMENT

**MOTION:** Padmaja Doniparthi moved, seconded by Lee Ann Lau, to adjourn the meeting. Motion carried unanimously.

The meeting adjourned at 10:29 a.m.

**State of Wisconsin  
Department of Safety & Professional Services**

**AGENDA REQUEST FORM**

1) Name and Title of Person Submitting the Request:		2) Date When Request Submitted:  3/8/2018	
		Items will be considered late if submitted after 12:00 p.m. on the deadline date which is 8 business days before the meeting	
3) Name of Board, Committee, Council, Sections:  Medical Examining Board			
4) Meeting Date:  3/21/2018	5) Attachments:  <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? FSMB Matters 2018 Annual FSMB Meeting - Resolutions, Reports and Candidate Nominations - Board Discussion	
7) Place Item in:  <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session	8) Is an appearance before the Board being scheduled?  <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	9) Name of Case Advisor(s), if required:  N/A	
10) Describe the issue and action that should be addressed:  Please see the attached materials outlining Resolutions, Reports, Candidate Nominations to be addressed at the 2018 FSMB Annual Meeting.			
11) Authorization			
Signature of person making this request		Date	
Supervisor (if required)		Date	
Executive Director signature (indicates approval to add post agenda deadline item to agenda)     Date			
Directions for including supporting documents: 1. This form should be attached to any documents submitted to the agenda. 2. Post Agenda Deadline items must be authorized by a Supervisor and the Policy Development Executive Director. 3. If necessary, provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.			

## Wood, Kimberly - DSPS

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**From:** Ryan, Thomas - DSPS  
**Sent:** Friday, March 02, 2018 7:14 AM  
**To:** Wood, Kimberly - DSPS  
**Subject:** FW: UPDATE RE: Reports and Resolutions  
**Attachments:** BRD RPT 18-2 (PDMP).pdf

Please added to FSMB matters. I had sent some other items earlier.

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**From:** Pamela Huffman (FSMB) [mailto:phuffman@fsmb.org]  
**Sent:** Thursday, March 01, 2018 5:14 PM  
**To:** Pamela Huffman (FSMB) <phuffman@fsmb.org>  
**Cc:** Patricia McCarty (FSMB) <pmccarty@fsmb.org>  
**Subject:** UPDATE RE: Reports and Resolutions

Dear Member Board Voting Delegates, Executive Staff Scholarship Recipients, Presidents/Chairs and Executive Directors:

Attached for your review is **BRD RPT 18-2, Report of the Workgroup on Prescription Drug Monitoring Programs** that will be presented to the 2018 House of Delegates for action on April 28. You should have already received the following documents from Pat McCarty last week:

### **Six (6) resolutions:**

Resolution 18-1: Acute Opioid Prescribing Workgroup and Guidelines (OH)  
Resolution 18-2: Testing Under Time Constraints of the Necessary and Explicit Component of the USMLE (MN)  
Resolution 18-3: Supporting the Practice of Physician Assistants (WA-M)  
Resolution 18-4: Permitting Out-of-State Practitioners to Provide Continuity of Care in Limited Situations (WA-M)  
Resolution 18-5: Interprofessional Continuing Education (FSMB BOD)  
Resolution 18-6: Workgroup on AI and Its Potential Impact on Patient Safety and Quality of Care in Medical Practice (PA-M)

### **Four (4) additional Board Reports:**

BRD RPT 18-1: Report of the Workgroup to Study Regenerative and Stem Cell Therapy Practices  
BRD RPT 18-3: Report of the FSMB Workgroup on Physician Wellness and Burnout  
BRD RPT 18-4: Guidelines for the Structure and Function of a State Medical and Osteopathic Board  
BRD RPT 18-5: Report on Resolution 17-2: Advocacy for Professional Licensure of EMS Providers

The **Report of the Bylaws Committee** and a **REVISED Report of the Nominating Committee**.

If you did not receive the aforementioned materials, please let me know and I will be happy to forward the same to you.

Warmest regards,  
Pam

**Pamela Huffman**  
Governance Support Associate

Leadership Services

**Federation of State Medical Boards**

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Federation of State Medical Boards  
House of Delegates Meeting  
April 28, 2018

Subject: Acute Opioid Prescribing Workgroup and Guidelines  
Introduced by: State Medical Board of Ohio  
Approved: January 2018

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- Whereas,* long-term use of opioids frequently begins with the treatment of acute pain; and
- Whereas,* millions of Americans undergo surgical procedures and sustain painful injuries every year; and
- Whereas,* many, if not most, people have their first exposure to opioids in the acute medical and postoperative settings; and
- Whereas,* acute medical and postoperative prescribing varies widely by prescriber; and
- Whereas,* the duration, dosage, and formulation of opioids can have a dramatic impact on the likelihood of risk of acute medical and postoperative persistent opioid use; and
- Whereas,* prescriber awareness of risk factors for persistent opioid use could deter overprescribing of opioids, which could lead to a decreased incidence of long-term opioid use. This would lead to a decreased incidence of addiction, comorbidity, and diversion; and
- Whereas,* a number of states may be considering – or have already implemented – rules or laws limiting the permissible number of days, morphine equivalency and type of opioid to prescribe for acute conditions; and
- Whereas,* prescribers frequently practice in multiple states in which acute opioid prescribing laws and rules may vary significantly;

Therefore, be it hereby

- Resolved,* that the Federation of State Medical Boards (FSMB) perform a comprehensive review of acute opioid prescribing patterns, practices, federal laws and guidance (including Centers for Disease Control and Prevention guidelines), and state rules and laws across the United States; and
- Resolved,* that the FSMB perform a comprehensive review of data related to patient outcomes, comparing states with and without limitations on opioid prescribing for acute conditions; and

***Resolved,*** that the FSMB establish a workgroup tasked to formulate acute opioid prescribing guidelines and best practices, and to present these guidelines and best practices to the House of Delegates at the FSMB annual meeting in 2019.

**Federation of State Medical Boards  
House of Delegates Meeting  
April 28, 2018**

Subject: Testing Under Time Constraints of the Necessary and Explicit Component of the United States Medical Licensure Examination (USMLE)

Introduced by: Minnesota Board of Medical Practice

Approved: November 2017

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*Whereas,* the USMLE is an exam used for licensure by states; and

*Whereas,* the USMLE is used to determine the safety of physicians in the independent practice of medicine; and

*Whereas,* the practice of medicine is constrained by time; and

*Whereas,* the USMLE has been publicized as a test of knowledge; and

*Whereas,* testing under time constraint is not considered a component of the USMLE;

Therefore, be it hereby

*Resolved,* that the Federation of State Medical Boards study and consider the addition of testing time constraint as an explicit component of the USMLE examination.

Federation of State Medical Boards  
House of Delegates Meeting  
April 28, 2018

Subject: Supporting the Practice of Physician Assistants

Introduced by: Washington State Medical Commission

Approved: January 2018

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**Whereas,** a recent study estimates that by 2025, the US will face a shortfall of between 61,000 and 94,000 physicians, a third of them in primary care; and

**Whereas,** many US citizens live in medically underserved areas and lack access to primary care; and

**Whereas,** the profession of physician assistant is rooted with physicians in the medical team-based model, with physician assistant choice, flexibility of practice area, and degree of practice independence considered a benefit of the profession; and

**Whereas,** numerous outcome studies show physician assistants provide affordable, high quality primary care to patients; and

**Whereas,** physician assistants play a vital role in easing the health care shortage and expanding access to primary care in underserved areas, but are limited by state laws; and

**Whereas,** permitting qualified physician assistants to conduct Optimal Team Practice up to the full scope of their education and training, subject to approval by their state medical board, is a natural and logical evolution of the profession and will help ease the physician shortage and improve access to primary care; and

**Whereas,** medical boards are better able to meet their mandate to ensure licensees are qualified, to discipline unethical or incompetent practitioners, and to set professional standards, when the boards include physician assistants as full members;

Therefore, be it hereby

**Resolved,** that the Federation of State Medical Boards (FSMB) shall adopt an advocacy position for the voluntary full Optimal Team Practice of physician assistants up to the full scope of their education and training; and be it further

**Resolved,** that the FSMB will revise the “Elements of a State Medical and Osteopathic Board” and the “Essentials of a State Medical and Osteopathic Practice Act,” to recommend that all medical boards integrate physician assistants as full members with proportional representation or other method deemed acceptable; and be it further

- Resolved,*** that the FSMB will collaborate with national hospital, clinic, and credentialing employer groups to establish guidelines and best practices for on the job training programs for physician assistants that promote best clinical outcomes and the highest standards of practice; and be it further
- Resolved,*** that the FSMB will provide support to fully integrate physician assistant regulatory bodies and their representatives into all relevant aspects of FSMB operations and offerings as full members; and be it further
- Resolved,*** that the FSMB will create a dedicated physician assistant position on the Board of Directors, but shall not limit the physician assistant representation on the Board to that single position; and be it further
- Resolved,*** that the FSMB will provide support, upon request, to state medical boards to amend their laws to permit the voluntary full and independent practice of physician assistants up to their education and training; and be it further
- Resolved,*** that the FSMB will collaborate with the USMLE and its stakeholders to allow physician assistants to take the appropriate levels of the exam and satisfy requirements for licensing bodies in lieu of or in addition to other national exams; and be it further
- Resolved,*** that the FSMB will advocate on the federal level to identify and address regulatory barriers which impede recognition of the voluntary full Optimal Team Practice of physician assistants in all federal institutions.

## References

1. ARNPs and PAs as Usual Source of Care: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2794129/>
2. PAs and ARNPs in Team Based Settings of Chronic Care Patients: <http://www.med.wisc.edu/news-events/study-supports-team-role-for-physician-assistants-and-nurse-practitioners-for-chronic-illness/42167>
3. PA use in Oncology Settings Related to Patient Outcomes: <http://ascopubs.org/doi/full/10.1200/jop.2012.000841>
4. PA Hospitalists in Community Hospital Settings lead to lower costs with Similar Outcomes: <http://www.healio.com/internal-medicine/practice-management/news/online/%7Bdcb0874d-da5b-482b-bb20-bfb9886f62d9%7D/increased-use-of-physician-assistants-can-reduce-costs-without-significant-impact-on-patient-outcomes>
5. Kaiser Family Literature Review comparing NPs and PAs: <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8167.pdf>

Federation of State Medical Boards  
House of Delegates Meeting  
April 28, 2018

Subject: Permitting Out-of-State Practitioners to Provide Continuity of Care in Limited Situations

Introduced by: Washington State Medical Commission

Approved: January 2018

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*Whereas,* state medical boards are responsible for protecting the citizens of their states by ensuring that physicians are qualified and competent; and

*Whereas,* state medical boards determine, within the context of their enabling statutes, under what circumstances a license is required for a physician to treat a patient in their states; and

*Whereas,* many states have license reciprocity and/or the Interstate Medical License Compact which establishes reliance on sister state licensing processes; and

*Whereas,* due to rapid changes in telemedicine technology, the practice of medicine is occurring more frequently across state lines; and

*Whereas,* telemedicine is a tool that has the potential to increase access, lower costs, and improve the quality of healthcare; and

*Whereas,* the historic practice of medicine has prioritized the continuity of care delivery to established patients over recognition of jurisdictional boundaries; and

*Whereas,* continuity of care is an essential element in consistently delivering high quality health care; and

*Whereas,* physicians can promote continuity of care by using telemedicine to provide follow-up care to established patients who travel outside the physician's state of licensure. For example, a physician at a major academic medical center who treats a patient who then returns home, can maintain a connection with the patient by providing follow-up care, including having access to timely and accurate data from the patient; and

*Whereas,* permitting physicians who are duly licensed in another jurisdiction to provide follow-up care to established patients, and to engage in peer-to-peer consultations, will result in better outcomes and lower costs;

Therefore, be it hereby

*Resolved,* that the Federation of State Medical Boards (FSMB) will encourage state medical boards to interpret their licensing laws, or work to change their licensing laws if

necessary, to permit physicians duly licensed in another jurisdiction to provide infrequent and episodic continuity of care by providing follow-up care to established patients or a peer-to-peer consultation without the need to obtain a license in the state in which the patient is located at the time of the interaction.

Federation of State Medical Boards  
House of Delegates Meeting  
April 28, 2018

Subject: Interprofessional Continuing Education (IPCE)  
Introduced by: FSMB Board of Directors  
Approved: February 2018

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- Whereas,* a commitment to lifelong learning and continuing professional development is critical to a physician’s ability to keep up with advances in medicine and with changes in the delivery of care; and
- Whereas,* state medical and osteopathic boards require continuing medical education for license renewal as a means of assuring the public that licensed physicians are maintaining their competence; and
- Whereas,* insufficient communication and coordination of care between physicians and other health care professionals in team-based care settings is a patient safety issue; and
- Whereas,* interprofessional education and team-based care among physicians, nurses and pharmacists is a critical component of health care delivery and improvement; and
- Whereas,* the Federation of State Medical Boards (FSMB) works with the National Council of State Boards of Nursing (NCSBN) and the National Association of Boards of Pharmacy (NABP) to support collaborative educational opportunities, including regularly hosting Tri-Regulator Meetings for state and territorial licensing boards for medicine, nursing and pharmacy; and
- Whereas,* Interprofessional Continuing Education (IPCE) is defined as a process by which individuals from two or more professions learn with, from, and about each other to enable effective collaboration and improve health outcomes; and
- Whereas,* a Joint Accreditation system for Interprofessional Continuing Education was launched in 2009 that is a collaboration of the Accreditation Council for Continuing Medical Education (ACCME®), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC); and
- Whereas,* the Joint Accreditors have adopted a shared credit (IPCE credit) that designates an educational activity as having been planned by and for an interprofessional team;

Therefore, be it hereby

*Resolved,* that the Federation of State Medical Boards supports and recognizes Interprofessional Continuing Education for physicians that is identified by IPCE credit and is accredited by the Joint Accreditation system launched by the Accreditation Council for Continuing Medical Education, the Accreditation

Council for Pharmacy Education and the American Nurses Credentialing Center, as an additional means of satisfying continuing medical education requirements for medical license renewal.

Federation of State Medical Boards  
House of Delegates Meeting  
April 28, 2018

**Subject:** Workgroup on AI and its Potential Impact on Patient Safety and Quality of Care in Medical Practice

**Introduced by:** Pennsylvania State Board of Medicine

**Approved:** February 2018

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*Whereas,* The Internet can gather large amounts of data from diverse sources that include but are not limited to electronic health records, digital images, and mobile apps; and

*Whereas,* Technology enables the compilation, storage, and processing of vast amounts of data to help identify clinically significant patterns and provide predictions; and

*Whereas,* Recent developments propel interest in healthcare AI, whether defined as “artificial intelligence,” the ability of a computer to complete tasks in a manner typically associated with a rational human being, or “augmented intelligence,” design that enhances human intelligence rather than replaces it; and

*Whereas,* Healthcare AI has been developed and applied to clinical decision support, treatment protocols, diagnostic recommendations, clinical prognostication, drug development, personalized medicine, patient monitoring, chronic care, and patient flow analytics; and

*Whereas,* Healthcare AI operates with variable levels of transparency, vetting, and oversight by experts and regulators; and

*Whereas,* Technology industry leaders and academic institutions have developed and implemented healthcare AI for radiology, pathology, oncology, ophthalmology, cardiology, and dermatology, and further applications are anticipated;<sup>1-13</sup> and

*Whereas,* Modern machine learning technology in healthcare AI can readily re-identify data sources posing a challenge to confidentiality of protected health information;<sup>14</sup> and

*Whereas,* Investment in healthcare AI is robust and a recent report from Markets and Markets pins the healthcare AI sector at nearly \$8 billion in 2022, accelerating at a compound annual growth rate of 52.68 percent over the forecast period;<sup>15, 16</sup> and

*Whereas,* State medical boards should have an understanding of AI and its impact on medical practice;

Therefore, be it hereby

**Resolved,** That the Federation of State Medical Boards will convene a workgroup comprised of relevant stakeholders and subject matter experts including the American Medical Association to provide state medical boards with an understanding of AI and its potential impact on patient safety and quality of care in medical practice.

<sup>1</sup> IBM: *IBM Watson Health Closes Acquisition of Truven Health Analytics*. <https://www-03.ibm.com/press/us/en/pressrelease/49474.wss>.

<sup>2</sup> ARS Technica. *IBM's Watson Proves Useful at Fighting Cancer-Except in Texas*. <https://arstechnica.com/science/2017/02/ibms-watson-proves-useful-at-fighting-cancer-except-in-texas/>.

<sup>3</sup> Xconomy: *Microsoft's Strategy for Finding What's Next in Healthcare AI*. <https://www.xconomy.com/seattle/2017/11/08/microsofts-strategy-for-finding-whats-next-in-healthcare-a-i/>.

<sup>4</sup> Google Inc.: *Detecting Cancer Metastases on Gigapixel Pathology Images*. <https://arxiv.org/abs/1703.02442>.

<sup>5</sup> Dai W, et al. *Prediction of hospitalizations due to heart diseases by supervised learning methods*. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4314395/pdf/nihms643126.pdf>.

<sup>6</sup> Esteva A, et al. *Dermatologist-level classification of skin cancer with deep neural networks*. Nature (42) 115, 2017.

<sup>7</sup> JASON: *Artificial Intelligence for Health and Health Care*. MITRE Corporation, December 2017.

<sup>8</sup> GulshanV, et al. *Development and Validation of a Deep Learning Algorithm for Detection of Diabetic Retinopathy in Retinal Fundus Photographs*. <https://jamanetwork.com/journals/jama/fullarticle/2588763>.

<sup>9</sup> HealthIT News. *Google powers up AI, machine learning accelerator for healthcare*. <http://www.healthcareitnews.com/news/google-powers-ai-machine-learning-accelerator-healthcare>.

<sup>10</sup> Yu KH, et al. *Predicting non-small cell lung cancer prognosis by fully automated microscopic pathology image features*. <https://www.nature.com/articles/ncomms12474>.

<sup>11</sup> Gibbons C, et al. *Supervised Machine Learning Algorithms Can Classify Open-Text Feedback of Doctor Performance With Human-Level Accuracy*. <http://www.jmir.org/2017/3/e65/>.

<sup>12</sup> Rajwa B, et al. *Automated Assessment of Disease Progression in Acute Myeloid Leukemia by Probabilistic Analysis of Flow Cytometry Data*. <http://ieeexplore.ieee.org/document/7511726/?part=1>.

<sup>13</sup> Dai W, et al. *Prediction of hospitalizations due to heart diseases by supervised learning methods*. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4314395/pdf/nihms643126.pdf>.

<sup>14</sup> Osoba O, et al. *An Intelligence in Our Image: The Risks of Bias and Errors in Artificial Intelligence*: RAND Corporation, 2017.

<sup>15</sup> CB Insights. *The Race for AI: Google, Baidu, Intel, Apple in a Rush to Grab Artificial Intelligence Startups*. <https://www.cbinsights.com/research/top-acquirers-ai-startups-ma-timeline/>.

<sup>16</sup> MarketsandMarkets. *Artificial Intelligence in Healthcare Market by Offering (Hardware, Software and Services), Technology (Deep Learning, Querying Method, NLP, and Context Aware Processing), Application, End-User Industry, and Geography – Global Forecast to 2022*. <https://www.marketsandmarkets.com/Market-Reports/artificial-intelligence-healthcare-market-54679303.html>

## REPORT OF THE BOARD OF DIRECTORS

**Subject:** Report of the FSMB Workgroup to Study Regenerative and Stem Cell Therapy Practices

**Referred to:** Reference Committee B

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The Federation of State Medical Boards (FSMB) Workgroup to Study Regenerative and Stem Cell Therapy Practices was convened in May of 2017 by FSMB Chair Gregory B. Snyder, M.D., DABR, in response to a letter from U.S. Senator Lamar Alexander (R-TN), Chairman of the U.S. Senate Health, Education, Labor, and Pensions (HELP) Committee, urging the FSMB to develop best practices for state medical and osteopathic boards (hereinafter referred to as “state medical boards”) in regulating the promotion, communication, and practices of treatments received at stem cell clinics in the United States.

Members of the Workgroup are: Scott A. Steingard, DO, Chair (FSMB Director-at-Large, Past President, Arizona Board of Osteopathic Examiners in Medicine and Surgery); Debbie J. Boe (Former Public Member, Minnesota Board of Medical Practice); Sandra L. Coletta (Public Member, Rhode Island Board of Medical Licensure and Discipline); Sarah L. Evenson, JD, MBA (Former Public Member, Minnesota Board of Medical Practice); H. Joseph Falgout, MD (Chair, Alabama Board of Medical Examiners); Joseph E. Fojtik, MD, FACP (Deputy Medical Coordinator, Illinois Department of Financial & Professional Regulation); Gary R. Hill, DO (Member, Alabama Medical Licensure Commission); Howard R. Krauss, MD (Member, Medical Board of California). Subject matter experts included: Ronald E. Domen, MD, FACP, FCAP (Penn State College of Medicine); Zubin Master, PhD (Mayo Clinic); Douglas Oliver, MSW; and Bruce D. White, DO, JD (Alden March Bioethics Institute). Participating ex officio were Gregory B. Snyder, MD, DABR, FSMB Chair; Patricia A. King, MD, PhD, FACP, FSMB Chair-elect; and Humayun J. Chaudhry, DO, MS, MACP, MACOI, FSMB President and CEO.

The Workgroup was charged with: 1) evaluating the prevalence, promotional practices, and incidences of patient harm related to regenerative medicine and adult stem cell therapies in the U.S.; 2) evaluating current regulatory approaches that will protect the public, recognizing the potential for improved patient outcomes through health innovation and technology; 3) identifying best practices for state medical and osteopathic boards in investigating complaints of patient harm, fraud, and compliance with licensure requirements; and 4) issuing a report on the Workgroup’s findings from prevailing research and recommending best regulatory practices and guidelines related to physicians’ use of regenerative medicine and adult stem cell therapies in a manner consistent with safe and responsible medicine.

The Workgroup met in person in Washington, D.C. on September 7, 2017 and by teleconference on December 11, 2017.

In completing its charge, the Workgroup drafted its report in the form of a guidance document, with recommendations that address the regulation of the provision of stem cell and regenerative therapies, as well as their promotion and communication to patients, and documentation of treatments provided. The recommendations do not address which uses are appropriate or for specific conditions or symptoms, as this area of medicine continues to be dynamic and subject to change. Rather, the recommendations focus on sensible and necessary principles of patient safety, autonomy, and non-exploitation.

A draft of the report was distributed to FSMB member boards and other key stakeholder organizations in December 2017 with comments due January 26, 2018. The draft report was distributed to the American Medical Association (AMA), American Osteopathic Association (AOA), Council of Medical Specialty Societies (CMSS), U.S. Food and Drug Administration (FDA), Office of U.S. Senator Lamar Alexander (R-TN), Association of Clinical Research Organizations (ACRO), and others for comment. Minimal comments were received, and all were generally positive.

The FSMB Board of Directors considered the draft *Report of the FSMB Workgroup to Study Regenerative and Stem Cell Therapy Practices* at its meeting on February 8, 2018 in Washington D.C. and discussed clarifications to the document.

**ITEM FOR ACTION:**

**The Board of Directors recommends that:**

**The House of Delegates ADOPT the *Report of the FSMB Workgroup to Study Regenerative and Stem Cell Therapy Practices*, and the remainder of the Report be filed.**

# **Attachment 1**

1 **REPORT OF THE FSMB WORKGROUP TO STUDY REGENERATIVE AND**  
2 **STEM CELL THERAPY PRACTICES**  
3  
4

5 **Section One. Introduction and Charge:**  
6

7 The Federation of State Medical Boards (FSMB) Workgroup to Study Regenerative and Stem  
8 Cell Therapy Practices was convened in May of 2017 by FSMB Chair Gregory B. Snyder, M.D.,  
9 DABR, in response to a letter (Attachment 1) from U.S. Senator Lamar Alexander (R-TN),  
10 Chairman of the U.S. Senate Health, Education, Labor, and Pensions (HELP) Committee, urging  
11 the FSMB to develop best practices for state medical and osteopathic boards (hereinafter  
12 referred to as “state medical boards”) in regulating the promotion, communication, and  
13 practices of treatments received at stem cell clinics in the United States.  
14

15 In order to address Senator Alexander’s request, Dr. Snyder charged the Workgroup with:  
16

- 17 1) Evaluating the prevalence, promotional practices, and incidences of patient harm  
18 related to regenerative medicine and adult stem cell therapies in the U.S.;
- 19
- 20 2) Evaluating current regulatory approaches that will protect the public, recognizing the  
21 potential for improved patient outcomes through health innovation and technology;  
22
- 23 3) Identifying best practices for state medical and osteopathic boards in investigating  
24 complaints of patient harm, fraud, and compliance with licensure requirements; and  
25
- 26 4) Issuing a report on the Workgroup’s findings from prevailing research and  
27 recommending best regulatory practices and guidelines related to physicians’ use of  
28 regenerative medicine and adult stem cell therapies in a manner consistent with safe  
29 and responsible medicine.  
30

31 Stem cell and regenerative therapies offer opportunities for advancement in the practice of  
32 medicine and the possibility of an array of new treatment options for patients experiencing a  
33 variety of symptoms and conditions. Despite significant momentum in research and  
34 development, and the potential for such medical advancements, there is reasonable concern  
35 about a growing number of providers and clinics in the United States that are undermining the  
36 field. Such providers and clinics have been known to apply, prescribe or recommend therapies  
37 inappropriately, over-promise without sufficient data to support claims, and exploit patients  
38 who are often in desperate circumstances and willing to try any proposed therapy as a last  
39 resort, even if there is excessive cost or scant evidence of efficacy.  
40

41 The following report aims to raise awareness about regenerative and stem cell therapy  
42 practices generally, outline their potential benefits and risks, and provide basic guidance for  
43 state medical boards and licensed physicians and physician assistants. Central to all of the

44 recommendations provided herein is a range of imperatives, including the importance of  
45 protecting the public, respecting patient autonomy, preventing patient exploitation, obtaining  
46 informed consent, and appropriately documenting care that is recommended and provided.  
47

48 The Workgroup’s deliberations were aided by participants and subject matter experts who  
49 brought varying perspectives. For example, Dr. Ronald Domen has expertise in stem cell  
50 therapies, bioethics and humanities, and has served on numerous ethics committees at  
51 institutional, state, and national levels. Dr. Zubin Master of the Mayo Clinic has extensive  
52 training and education in cellular and molecular biology, bioethics and genetics, as well as  
53 research and publications on stem cell therapies. Mr. Douglas Oliver became known to the  
54 Workgroup through a recommendation by Senator Lamar Alexander of Tennessee, was a  
55 recipient of stem cell therapies himself, and has a foundation that advocates for stem cell  
56 therapies based on his own experiences and those of others like him. Dr. Bruce White has  
57 educational backgrounds in medicine, law, pharmacy and ethics and currently serves as  
58 Director of the Alden March Bioethics Institute at Albany Medical College and is Chair of  
59 Medical Ethics at the College. The Workgroup also received written comments from several  
60 external organizations. The sum of these perspectives aided the Workgroup in producing a  
61 balanced report on this emerging issue of national importance.  
62  
63

## 64 **Section Two. Definitions:**

65  
66 Homologous (Allogeneic) Use: the repair, reconstruction, replacement, or supplementation of a  
67 recipient's cells or tissues with a HCT/P (human cells, tissues, and cellular and tissue-based  
68 product) that performs the same basic function or functions in the recipient as in the donor,  
69 including when such cells or tissues are for autologous use.<sup>1</sup>  
70

71 According to the Food and Drug Administration’s (FDA) *Regulatory Considerations for*  
72 *Human Cell, Tissues, and Cellular and Tissue-Based Products: Minimal Manipulation and*  
73 *Homologous Use / Guidance for Industry and Food and Drug Administration Staff*  
74 *(November 2017)*, the FDA “generally considers an HCT/P to be for homologous use  
75 when it is used to repair, reconstruct, replace, or supplement:

- 76 • Recipient cells or tissues that are identical (e.g., skin for skin) to the donor cells  
77 or tissues, and perform one or more of the same basic functions in the recipient  
78 as the cells or tissues performed in the donor; or
- 79 • Recipient cells or tissues that may not be identical to the donor’s cells or  
80 tissues, but that perform one or more of the same basic functions in the  
81 recipient as the cells or tissues performed in the donor.”<sup>2</sup>  
82

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<sup>1</sup> 21 CFR 1271.3(c)

<sup>2</sup>U.S. Food and Drug Administration (November 2017). *Regulatory Considerations for Human Cells, Tissues, and Cellular and Tissue-Based Products: Minimal Manipulation and Homologous Use Guidance for Industry and Food and Drug Administration Staff.*

83 Autologous Use: the implantation, transplantation, infusion, or transfer of human cells or tissue  
84 back into the individual from whom the cells or tissue were recovered.<sup>3</sup>

85  
86 Informed and Shared Decision Making: The process by which a physician discusses, in the  
87 context of the use of regenerative and stem cell therapies, the risks and benefits of such  
88 treatment with the patient.<sup>4</sup> The patient is given an opportunity to express preferences and  
89 values before collaboratively evaluating and arriving at treatment decisions.<sup>5</sup>

90  
91 Informed Consent:<sup>6</sup> Evidence documenting appropriate patient informed consent typically  
92 includes the following elements:

- 93 • Identification of the patient, the physician, and the physician’s credentials;
- 94 • Types of transmissions permitted using regenerative and stem cell therapies (e.g.  
95 prescription refills, appointment scheduling, patient education, etc.);
- 96 • Agreement from the patient with the physician’s determination about whether or not  
97 the condition being diagnosed and/or treated is appropriate for regenerative and stem  
98 cell therapy;<sup>7</sup> and
- 99 • Express patient consent to forward patient-identifiable information to a third party
- 100 • An accurate description of the benefits and risks of treatment or intervention, based  
101 on scientific evidence, as well as an explanation of alternatives to treatment or an  
102 intervention, and the right to withdraw from treatment or an intervention without  
103 denial of standard of care to patients.

104  
105 Minimal Manipulation: (minor processing including purification, centrifugation, washing,  
106 preservation, storage) – the Food and Drug Administration (FDA) argues that it has the  
107 authority to regulate anything beyond minimal manipulation and homologous use:  
108 “(1) For structural tissue, processing that does not alter the original relevant characteristics of  
109 the tissue relating to the tissue’s utility for reconstruction, repair, or replacement; and  
110 (2) For cells or nonstructural tissues, processing that does not alter the relevant biological  
111 characteristics of cells or tissues.”<sup>8</sup>

112

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<sup>3</sup> 21 CFR 1271.3(a)

<sup>4</sup> Federation of State Medical Boards (2016). Model Guidelines for the Recommendation of Marijuana in Patient Care.

<sup>5</sup> Barry, MJ, Edgman-Levitan, S. (2012). Shared Decision Making – The Pinnacle of Patient-Centered Care. *N Engl J Med*, 366:780-781.

<sup>6</sup> With respect to informed consent for the purposes of research studies involving human subjects, researchers should be aware of the basic elements of informed consent outlined in 21 CFR Part 50.25 “Protection of Human Subjects.”

<sup>7</sup> Federation of State Medical Boards (2014). Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine.

<sup>8</sup> 21 CFR 1271.3(f)

113 Unproven Stem Cell Intervention: Stem cell therapy that lacks compelling evidence, based upon  
114 scientific studies, to validate its treatment efficacy.<sup>9</sup>  
115  
116

117 **Section Three. Background, Prevalence and Marketing of Regenerative and Stem Cell**  
118 **Therapies:**  
119

120 Historically, many of the clinics providing unproven stem cell interventions fell under the  
121 definition of “stem cell tourism” because most patients seeking such interventions had to travel  
122 outside of North American jurisdictions to receive them. The landscape in the United States has  
123 evolved considerably over the last few years with hundreds of new clinics opening across the  
124 country and many more physicians willing to provide stem cell and regenerative therapies. A  
125 study identified 351 U.S. businesses with over 570 clinics engaged in direct-to-consumer (DTC)  
126 marketing of stem cell interventions.<sup>10</sup> It has also been suggested that growth in this area of  
127 medicine, especially in terms of adult, amniotic, fat-derived and bone marrow stem cell  
128 therapies to treat a host of conditions and injuries, is accelerating, both in the U.S. and  
129 internationally, and, perhaps counterintuitively, such growth is noted to be most significant in  
130 jurisdictions with more stringent regulatory frameworks.<sup>11</sup>  
131

132 Stem cell clinics typically reach their patients through online DTC marketing, primarily through  
133 information provided on company websites. Data purportedly supporting unproven stem cell  
134 interventions commonly undermine information about risks and overemphasize information  
135 about benefits. Treatment options are described on such websites and are often accompanied  
136 by supporting information in the form of journal articles, patient testimonials, and accolades  
137 related either to the clinic itself or its affiliated physicians and researchers. Supporting  
138 information that accompanies marketing materials can appear to be legitimate, but can also  
139 overemphasize, exaggerate, inflate, or misrepresent information derived from legitimate (or  
140 even questionable) sources. A physician engaging in such practices of deceptive or false  
141 advertising can be in violation of a state’s *Medical Practice Act*. Information provided on clinic  
142 websites should be represented accurately and come from reputable peer-reviewed  
143 publications or respected external organizations.  
144

145 Some clinics, however, that are engaged in the provision of treatment modalities that lack  
146 evidence – or an appropriate rationale for application of that modality to particular medical  
147 conditions – often use what have been described as “tokens of scientific legitimacy” to lend  
148 credence to treatments offered or the quality of a clinic and its associated professionals.  
149 Examples of such tokens of legitimacy include patient or celebrity testimonials and

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<sup>9</sup> Sipp D, et al. (2017). Marketing of Unproven Stem Cell-Based Interventions: A Call to Action. *Science Translational Medicine*, 9:397.

<sup>10</sup> Turner L, Knoepfler P. (2016). Selling Stem Cells in the USA: Assessing the Direct-to-Consumer Industry *Cell Stem Cell* 19, August 4, 154-7.

<sup>11</sup> Berger, et al. (2016) Global Distribution of Businesses Marketing Stem Cell-Based Interventions. *Cell Stem Cell* 19, August 4, 158-62.

150 endorsements, clinician affiliations or memberships in academic or professional societies,  
151 registrations in clinical trials, claims of various types of certifications or awards, and others.<sup>12</sup>  
152 Further detail and explanations are provided in **Table 1**.

153  
154 Physicians are ordinarily permitted to advertise themselves, their practice and services offered,  
155 provided that such advertisements do not contain claims that may be deceptive or are  
156 intentionally false or misleading. Further, physicians should be mindful of ways in which patient  
157 testimonials, quality ratings, or other evaluative data is presented to prospective patients  
158 through advertisements. In advertising stem cell treatments to potential patients, physicians  
159 are responsible for ensuring that all information, especially in terms of risks, benefits and  
160 efficacy, is presented in an objective manner. Physicians must not deliberately misrepresent the  
161 expected outcomes or results of treatments offered. Physicians should be prepared to support  
162 any claims made about benefits of treatment(s) with documented evidence, for example with  
163 studies published in peer-reviewed publications.<sup>13</sup>

164  
165 Physicians must be accurate and not intentionally misleading in providing descriptions of their  
166 training, skills, or treatments they are able to competently offer to patients. This includes  
167 descriptions of one's specialization and any specialty board certifications.<sup>14</sup>

168  
169 A recent study on the prevalence and marketing practices of businesses offering stem cell  
170 treatments internationally noted the presence of the following elements in their marketing  
171 practices:

- 172
- 173 • Mention of affiliations with a professional society or network
  - 174 • Claims of partnerships with academic institutions
  - 175 • Statements of receipt of FDA approval, or explicit mention of exemption from FDA  
176 oversight
  - 177 • Mention of official endorsement from a local or other authority, or professional  
178 accreditation
  - 179 • Listing of patents granted
  - 180 • Statement that clinical trials of investigational stem cell-based interventions are being  
181 conducted<sup>15</sup>

182  
183 The marketing practices and information found on a business' website can be important  
184 sources of data for state medical boards as they investigate complaints made against physicians

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<sup>12</sup> Sipp D, et al. (2017). Marketing of Unproven Stem Cell-based Interventions: A Call to Action. *Sci. Transl. Med.* 9, eaag0426.

<sup>13</sup> Federation of State Medical Boards (2016). *Position Statement on Sale of Goods by Physicians and Physician Advertising*.

<sup>14</sup> *Ibid.*

<sup>15</sup> Berger, et al. (2016) Global Distribution of Businesses Marketing Stem Cell-Based Interventions. *Cell Stem Cell* 19, August 4, 158-62.

185 affiliated with businesses providing regenerative and stem cell treatments. Even where an  
 186 appropriate informed consent process seems to be in place, deceptive or fraudulent  
 187 information on clinic websites and other marketing materials could mislead patients into  
 188 consenting to treatment, thereby invalidating the informed consent process.

189  
 190 Physicians must make accurate claims about the enrollment process of subjects, treatments,  
 191 and products in clinical trials and are responsible for ensuring that any research conducted and  
 192 described in marketing materials is carried out according to accepted research protocols and  
 193 recognized standards. Physicians should consider consulting with Institutional Review Boards  
 194 (IRBs) to clarify processes and must seek IRB approval, where necessary. The National Institutes  
 195 of Health (NIH) provides helpful guidance on clinical trials and research methods.<sup>16</sup> Physicians  
 196 are also encouraged to consult the guidance contained in the *International Conference on*  
 197 *Harmonisation’s Harmonised Tripartite Guideline for Good Clinical Practice* to support  
 198 acceptability of clinical data by patients, state medical boards, and other regulatory  
 199 authorities.<sup>17</sup>

200  
 201 **Table 1: Co-opted Tokens of Scientific Legitimacy**<sup>18</sup>

Accreditations and awards	Asserting certification of products or practices by international standards organizations or claiming training certification
Boards and advisers	Convening scientific or medical advisory boards featuring prominent business leaders and academic faculty members
Clinical study registration	Registering trials whose apparent purpose is solely to attract patients willing to pay to participate in them
Ethics review	Using the imprimatur of “ethics review” to convey a sense of legitimacy to their products or procedures
Location	Renting of laboratory or business space within a legitimate scientific or government institution
Membership	Joining established academic or professional societies to suggest legitimacy by association
Outcome registries	Publication of open-ended voluntary monitoring data sets rather than undertaking controlled clinical trials
Patenting	Suggesting that patent applications or grants indicate clinical utility rather than initiation of an application process or recognition of novelty and inventiveness

16 National Institutes of Health, Office of Science Policy: <https://osp.od.nih.gov/clinical-research/clinical-trials/>

17 International Conference on Harmonisation of Technical Requirements for Registration of Pharmaceuticals for Human Use. (2016). ICH Harmonised Tripartite Guideline for Good Clinical Practice E6(R2).

18 Sipp D, et al. (2017). Marketing of Unproven Stem Cell-based Interventions: A Call to Action. *Sci. Transl. Med.* 9, eaag0426.

Publication	Publishing research and commentary in journals with limited anonymous peer review
Rationales	Citing preclinical and other research findings to justify clinical application without sufficient efficacy testing in humans
Self-regulation	Forming organizations to self-regulate in ways that support premature commercialization
Technical Language	Using scientific-sounding words that imply academic rigor
Testimonials and Endorsements	Providing expert opinions or celebrity comments on unsupported clinical uses or standing of the provider

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**Section Four. Patient Perceptions:**

In seeking treatment for any condition, patients desire safety and efficacy, but may overlook risks to their own safety or a lack of evidence of efficacy in favor of access to treatment, particularly in circumstances where traditional treatment options seem limited or have been exhausted. The power of hope also is known to play a significant role in how patients attempt to gain control over their illness and its potential treatments, thereby putting them in a position of increased vulnerability.<sup>19</sup> This is especially the case when patients and their families have overcome various obstacles on the path to a treatment, including raising large sums of money to pay for it. This can lead to a psychological predisposition to anticipate and assume a positive outcome, regardless of the treatment in question or the availability of compelling evidence.

Given the vulnerable state of some patients who seek regenerative and stem cell therapies, perhaps without the requisite knowledge for making informed decisions, there is increased potential for patient exploitation. Physicians must therefore be mindful of the ways in which at-risk or susceptible patients may process information and arrive at decisions about their treatment options, expectations, and ultimately, the potential for success. A promising way of navigating such difficult circumstances, where treatment options are uncertain or complex, is through the use of shared decision making. This process, whereby the physician describes the risks and benefits of potential treatment options and the patient is given an opportunity to express preferences and values before collaboratively arriving at and evaluating treatment decisions,<sup>20</sup> may help mitigate the risk of patient exploitation and ensure that consent to any treatment option has been provided in an informed manner.

The process of obtaining informed consent and engaging in shared decision making with patients involves conveying information about the reasonable effectiveness of a proposed treatment, as well as its risks and benefits. This can be particularly difficult with respect to regenerative and stem cell therapies, as this is an area of medicine that currently lacks

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<sup>19</sup> Petersen, et al. (2014). Therapeutic Journeys: The hopeful travails of stem cell tourists, *Sociology of Health & Illness*, 36(5):670-85, pp. 1–16.  
<sup>20</sup> Barry, MJ, Edgman-Levitan, S. (2012). Shared Decision Making – The Pinnacle of Patient-Centered Care. *N Engl J Med*, 366:780-781.

233 substantive data on efficacy. Generation of relevant data and evidence has not occurred to a  
234 sufficient enough degree and this is often blamed on the difficulty involved in organizing large-  
235 scale, randomized controlled trials as part of the approval process for novel therapies.  
236 However, the FDA has recently argued that a statistically significant 100% improvement in an  
237 outcome measure ( $\alpha = 0.05$ ,  $\beta = 0.1$ ) may be detected with a randomized trial involving as few  
238 as 42 participants.<sup>21</sup>

239  
240 The lack of a formal mechanism for reporting outcomes of unproven stem cell interventions,  
241 both positive and negative, adds to the difficulty involved in generating data on the  
242 effectiveness of such interventions, as does the fact that there is neither a requirement, nor a  
243 mechanism, for reporting adverse events related to interventions administered outside of  
244 clinical trials and investigations. In the current environment, this increases the importance of  
245 appropriate documentation of treatment(s) and ongoing care in patients' medical records. A  
246 centralized cell therapy registry for reporting treatment and outcomes may improve the current  
247 information available about the effectiveness of such therapies and interventions. It may also  
248 dissuade unscrupulous practitioners from engaging in the provision of unproven interventions  
249 without an adequate or appropriate basis in theory or peer-acknowledged practice, a pre-  
250 requisite for the provision of any intervention, whether proven or not.<sup>22</sup>

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252

### 253 **Section Five. Regulatory Landscape:**

254

255 The current state of affairs for regulatory oversight on regenerative and stem cell therapies  
256 (including human cells and tissues), at both the federal and state level, is evolving and will  
257 continue to change in the coming years. In November 2017, the FDA released two guidance  
258 documents to explain the Agency's current thinking on stem cell policy. However, this thinking,  
259 as well as the agency's jurisdiction and authority, may evolve in the future.

260

261 Until recently, the regulatory landscape for stem cell and regenerative therapies has been at  
262 times restrictive, allowing patients to access stem cell interventions only under the *Expanded*  
263 *Access to Investigational Drugs for Treatment Use* program. Treatments are eligible under this  
264 program if they are undergoing testing in a clinical trial and are subject to approval by the FDA.  
265 Three-quarters of the states in the nation have passed "Right to Try" legislation, however,  
266 which allows terminally ill patients to receive experimental therapies that have passed phase 1  
267 trials without seeking FDA approval.<sup>23</sup> The U.S. Congress is also considering similarly proposed

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<sup>21</sup> Marks PW, et al. (2017). Clarifying Stem-Cell Therapy's Benefits and Risks, *NEJM* 376;11, 1007-9.

<sup>22</sup> White, BD, Gelinas, LC, (2016). "Balancing the Surgeon's Responsibility to Individuals and Society," published in S.C. Stain et al. (eds.), *The SAGES Manual Ethics of Surgical Innovation*, Switzerland: Springer International Publishing, 191-211.

<sup>23</sup> *Lancet* Commission: Stem Cells and Regenerative Medicine. Published Online October 4, 2017 [http://dx.doi.org/10.1016/S0140-6736\(17\)31366-1](http://dx.doi.org/10.1016/S0140-6736(17)31366-1)

268 legislation and in August of 2017, the U.S. Senate passed *S. 204, Trickett Wendler, Frank*  
269 *Mongiello, Jordan McLinn, and Matthew Bellina Right to Try Act of 2017*.

270  
271 The *21<sup>st</sup> Century Cures Act* (Public Law 114–255), signed into law in December of 2016,  
272 represents legislative efforts at the federal level to expand and accelerate patient access to  
273 treatment, in addition to promoting innovation in medical products and treatments. With  
274 respect to regenerative medicine, the Act amends Section 506 of the Federal Food, Drug, and  
275 Cosmetic Act (21 U.S.C. 356) by requiring expedited review for regenerative medicine therapies,  
276 including human cells and tissues, intended to treat, modify, reverse, or cure a serious or life-  
277 threatening disease or condition, where there is preliminary clinical evidence indicating that the  
278 drug has the potential to address unmet medical needs. There are also ongoing efforts at the  
279 federal level to ensure even greater access to treatments that are not subject to FDA approval  
280 prior to administration to patients.

281  
282 Regulation in the regenerative and stem cell therapy arena is continuing to evolve. Human cells,  
283 tissues, and cellular or tissue-based products (HCT/Ps) are currently regulated under Sections  
284 351 and 361 of the Public Health Service Act.<sup>24</sup> However, a HCT/P can be regulated solely under  
285 Section 361 of the PHS Act if it is:

- 286  
287 1. Minimally manipulated,  
288 2. Intended for homologous use only,  
289 3. Not combined with another article, and  
290 4. Either:  
291 a. Does not have a systemic effect and is not dependent upon the metabolic  
292 activity of living cells for its primary function; or  
293 b. Has a systemic effect or is dependent upon the metabolic activity of living cells  
294 for its primary function, and is for autologous use, use in a first or second-degree  
295 blood relative, or reproductive use.<sup>25</sup>

296  
297 The difference between an HCT/P that is regulated under both sections of the Public Health  
298 Service Act, as opposed to solely under Section 361, is significant for providers of stem cell  
299 treatments since the requirements for pre-market authorization of a product are much more  
300 stringent under Section 351 and require conducting clinical investigations under an  
301 investigational new drug (IND) application and obtaining a biologics license through the FDA,  
302 whereas requirements under Section 361 focus only on the prevention of communicable  
303 diseases.<sup>26</sup> This represents a lower regulatory threshold for HCT/Ps; their use and  
304 transplantation can be considered to fall under the practice of medicine and would, therefore,  
305 be regulated by state medical boards.

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<sup>24</sup> The Public Health Service Act of 1944 outlines a policy framework for federal and state cooperation in health services and provides for the licensing of biological products.

<sup>25</sup> 21 CFR 1271.10(a)

<sup>26</sup> United States Food and Drug Administration: Regulatory Considerations for Human Cell, Tissues, and Cellular and Tissue-Based Products: Minimal Manipulation and Homologous Use

306  
307 In regulating this evolving area of medical practice, state medical boards will need to strive to  
308 achieve an appropriate balance between respecting the autonomy of patients as they seek  
309 viable and reasonable treatment options, and adequately safeguarding them against the risks  
310 presented by novel, but often unproven and potentially dangerous, interventions. Results from  
311 a 2017 survey of its member boards conducted by the FSMB indicate that a third (n = 17) of the  
312 51 responding boards have investigated complaints against physicians related to regenerative  
313 medicine or stem cell therapy, and that eight of those boards have taken disciplinary action  
314 against physicians for issues relating to regenerative medicine or stem cell therapy.

315  
316 In ensuring that physicians offer regenerative and stem cell therapies in a manner that is  
317 consistent with safe and responsible practices, state medical boards should ensure that any  
318 treatment offered to patients is informed by an appropriate history and physical examination;  
319 such informed consent is obtained after an explanation has been provided describing risks,  
320 benefits, alternative treatment options, expected convalescence, and expected treatment  
321 outcomes; that relevant information about the clinical encounter and ongoing care plans has  
322 been documented in the patient's medical record; that the physician is appropriately trained in,  
323 and knowledgeable about the proposed treatment; and that the patient has not been coerced  
324 in any way into receiving treatment(s) or exploited through the charging of excessive fees.

325  
326 In order to implement best practices for regenerative and stem cell therapies, physicians must  
327 understand the relevant clinical issues and should obtain sufficient targeted continuing  
328 education and training.<sup>27</sup>

329  
330 The recommendations in the final section of this report provide further detail on various  
331 requirements that apply to the provision of regenerative and stem cell therapies that state  
332 medical boards may wish to consider.

### 333 334 335 **Section Six. Recommendations:**

336  
337 The recommendations that follow address the regulation of the provision of stem cell and  
338 regenerative therapies, as well as their promotion and communication to patients, and  
339 documentation of treatments provided. The recommendations do not address which uses are  
340 appropriate or not for specific conditions or symptoms, as this area of medicine continues to be  
341 dynamic and subject to change. Rather, they focus on sensible and necessary principles of  
342 patient safety, autonomy, and non-exploitation.

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<sup>27</sup> Federation of State Medical Boards (2017). *Guidelines for the Chronic Use of Opioid Analgesics*.

347 The FSMB recommends that:

348

349 1. Where evidence is unavailable for a particular treatment in the form of clinical trials or case  
350 studies, physicians must only proceed with an appropriate rationale for the proposed  
351 treatment, and justification of its use, in relation to the patient’s symptoms or condition. Novel,  
352 experimental, and unproven interventions should only be proposed when traditional or  
353 accepted proven treatment modalities have been exhausted. In such instances, there must still  
354 be a basis in theory or peer-acknowledged practice.<sup>28</sup>

355

356 2. State medical boards raise awareness among licensees of applicable federal and state  
357 legislation and guidelines regarding regenerative and stem cell therapies, including “right to  
358 try” legislation existing or pending at the state and federal levels. State medical boards should  
359 also keep their licensees and the public apprised of new developments and regulations in the  
360 field of regenerative and stem cell therapies. This may include educational resources, guidance  
361 documents, and appropriate industry and stakeholder information on a state medical board’s  
362 website. State medical boards should further provide information as to reporting procedures of  
363 adverse actions related to stem cell interventions.

364

365 3. State medical boards should examine their policies and rules addressing informed consent  
366 and consider expanding these to include a shared decision making framework that includes the  
367 following general elements at a minimum:

- 368 • An explanation, discussion, and comparison of treatment options with the patient
- 369 • An assessment of the patient’s values and preferences
- 370 • Arrival at a decision in partnership with the patient
- 371 • An evaluation of the patient’s decision in partnership with the patient

372

373 4. State medical boards should review professional marketing materials and claims, including  
374 any office/clinic and/or doctor websites, and information publicly available about an  
375 office/clinic or licensee on online blogs or social media, as information sources in the  
376 investigation of complaints made against physicians.

377

378 5. State medical boards should pro-actively monitor warning letters sent to licensees that are  
379 made publicly available on the FDA website in order to ascertain information, and consider  
380 opening an investigation, about licensees who may be engaged in other unscrupulous or  
381 unprofessional practices related to the provision of regenerative and stem cell therapy. State  
382 medical boards should investigate such practices, when appropriate, in conjunction with  
383 applicable state laws, policies, and procedures.<sup>29</sup>

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<sup>28</sup> White, BD, Gelinas, LC, (2016). “Balancing the Surgeon’s Responsibility to Individuals and Society,” published in S.C. Stain et al. (eds.), *The SAGES Manual Ethics of Surgical Innovation*, Switzerland: Springer International Publishing, 191-211.

<sup>29</sup> The FDA’s warning letters are available at the following address:

<https://www.fda.gov/ICECI/EnforcementActions/WarningLetters/default.htm>

385 6. Physicians must only offer treatments to patients for which they have a bona fide physician-  
386 patient relationship. Physicians must have received adequate and appropriate training, and be  
387 able to perform any proposed intervention safely and competently.<sup>30</sup>  
388

389 7. Physicians should employ a “shared decision making” process when discussing treatment  
390 options with patients. Physicians must avoid any claims that may be deceptive or are  
391 intentionally or knowingly false or misleading, especially in terms of making promises about  
392 uncertain or unrealistic outcomes.  
393

394 8. Physicians should not use gag orders (rulings that a case must not be discussed publicly) or  
395 disclaimers as a way to circumvent liability.  
396

397 9. Physicians should be prepared to support any claims made about benefits of treatments or  
398 devices with documented evidence, for example with studies published in peer-reviewed  
399 publications.  
400

401 10. Physicians should refrain from charging excessive fees for treatments provided. Further,  
402 physicians should not recommend, provide, or charge for unnecessary medical services, nor  
403 should they make intentional misrepresentations to increase the level of payment they  
404 receive.<sup>31</sup>  
405

406 11. Physicians should consult and educate patients about stem cell interventions and alert them  
407 to important resources available to the community. A list of selected resources is provided in  
408 **Appendix A.**  
409

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<sup>30</sup> Federation of State Medical Boards (2014). *Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine.*

<sup>31</sup> American Medical Association, *Code of Medical Ethics*, Opinion 11.3.1.

410 **APPENDIX A: SAMPLE LIST OF EDUCATIONAL RESOURCES ON REGENERATIVE AND STEM CELL THERAPY PRACTICES**

411

412 [The Australian Stem Cell Handbook 2015](#)

413

414 [Stem Cell Basics \(National Institutes of Health\)](#)

415

416 [Stem Cell Patient booklet \(Albany Medical College\)](#)

417

418 [A closer look at Stem Cells \(International Society for Stem Cell Research\)](#)

419

420 [Patient Handbook on Stem Cell Therapies \(International Society for Stem Cell Research\)](#)

421

422 [Stem Cell Tourism \(California Institute for Regenerative Medicine\)](#)

423

424 [The Power of Stem Cells \(California Institute for Regenerative Medicine\)](#)

425

426 [SCOPE: Learn About Stem Cells in Your Native Language \(The Niche\)](#)

DRAFT

427 **WORKGROUP TO STUDY REGENERATIVE AND STEM CELL THERAPY PRACTICES**

428

429 Scott A. Steingard, DO, Chair

430 FSMB Director-at-Large

431 Past President, Arizona Board of Osteopathic Examiners in Medicine and Surgery

432

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434 Former Public Member, Minnesota Board of Medical Practice

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442 H. Joseph Falgout, MD

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453

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457

458 Zubin Master, PhD

459 Mayo Clinic

460

461 Douglas Oliver, MSW

462 Patient Appointee

463 Founder and Executive Director, Regenerative Outcomes Foundation

464

465 Bruce D. White, DO, JD

466 Alden March Bioethics Institute

467

468 **EX OFFICIOS**

469 Gregory B. Snyder, MD, DABR

470 Chair, FSMB

471

472 Patricia A. King, MD, PhD, FACP

473 Chair-elect, FSMB

474

475 Humayun J. Chaudhry, DO, MS, MACP, MACOI

476 President and CEO, FSMB

**STAFF SUPPORT**

Jonathan Jagoda, MPP

Director, Federal Government Relations, FSMB

Mark Staz, MA

Director, Continuing Professional Development

## REPORT OF THE BOARDS OF DIRECTORS

**Subject:** *Prescription Drug Monitoring Programs (PDMPs), Report and Recommendations of the Workgroup on PDMPs*

**Referred to:** **Reference Committee B**

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In April 2017, the FSMB House of Delegates adopted Resolution 17-1, Mandatory Use of Prescription Drug Monitoring Programs which directed FSMB to –

- Establish a task force to study PDMP use in the U.S. and its territories;
- Evaluate whether mandatory PDMP use positively impacts patient outcomes and prescribing practices;
- Evaluate the feasibility of incorporating the PDMP into an electronic medical record system; and
- Develop recommendations regarding mandatory use of PDMP data by licensed prescribers and dispensers.

Accordingly, FSMB Chair Gregory B. Snyder, MD, DABR, appointed the Workgroup on Prescription Drug Monitoring Programs (PDMP) which was comprised of a diverse group of medical and policy stakeholders. Members of the Workgroup are: Anna Z. Hayden, DO, Chairman; J. Mark Bailey, DO, PhD (University of Alabama at Birmingham); Daniel Blaney-Koen, JD (American Medical Association); Mark E. Bowden, MPA, CMBE (IA); Shawn Brooks (U.S. Food and Drug Administration); Danna E. Droz, JD, RPh (National Association of Boards of Pharmacy); Robert P. Giacalone, JD, RPh (OH); Patrice A. Harris, MD, MA (American Medical Association); Robin N. Hunter Buskey, DHSc, PA-C (NC); William K. Hoser, MS, PA-C (VT-Medical); Christina A. Mikosz, MD, MPH (Centers for Disease Control); Rebecca Poston, MHL (Electronic-Florida Online Reporting of Controlled Substance Evaluation (E-FORCSE) Program); Louis J. Prues, DMin, MDiv, MBA (MI-Medical); Jean L. Rexford (CT); Thomas H. Ryan, JD, MPA (WI); Judy Staffa, PhD, RPh (U.S. Food and Drug Administration); and Joseph R. Willett, DO (MN). Participating ex officio were Gregory B. Snyder, MD, DABR; Patricia A. King, MD, PhD, FACP; and Humayun J. Chaudhry, DO, MACP, FSMB President/CEO.

The Workgroup was charged with evaluating the impact of mandatory PDMP query on patient outcomes and the prescribing of controlled substances; evaluating challenges to increasing PDMP utilization, including, but not limited to: a) authority to access; b) currency of data; c) Electronic Medical Record (EMR) integration; and d) interoperability; and developing recommendations to state medical and osteopathic boards (hereafter referred to as “state medical boards”) regarding physician utilization of PDMPs, including a recommendation regarding mandatory query.

To accomplish its charge, the Workgroup conducted a review of PDMP statutes, rules, and state medical board policies currently enacted across the United States, research reports and peer-reviewed articles in the medical literature and policy statements regarding the use of PDMP. The

report is provided as a guidance document for state medical boards and other state agencies to maximize the effective use of PDMPs.

The Workgroup met in person and via web conference to develop its report, *Prescription Drug Monitoring Programs (Attachment 1)*. A draft of the report was distributed to FSMB member boards and other key stakeholder organizations for comment in December 2017 with comments due January 26, 2018. Comments were generally supportive and have been incorporated to the extent that they did not substantively conflict with the Workgroup's recommendations. The FSMB Board of Directors considered the draft report at its meeting on February 8, 2018 in Washington D.C. and discussed clarifications to the document.

**ITEM FOR ACTION:**

**The Board of Directors recommends that:**

**The House of Delegates ADOPT the recommendations in the report, *Prescription Drug Monitoring Programs*, and the remainder of the report be filed.**

# Attachment 1

1                                    **PRESCRIPTION DRUG MONITORING PROGRAMS (PDMPs)**  
2                                    *Report and Recommendations of the Workgroup on PDMPs*  
3

4                    **INTRODUCTION**  
5

6                    In April 2017, the Federation of State Medical Boards (FSMB) Chair, Gregory B. Snyder, MD,  
7                    DABR, appointed a Workgroup on Prescription Drug Monitoring Programs (PDMP) in  
8                    accordance with FSMB Resolution 17-1: Mandatory Use of Prescription Drug Monitoring  
9                    Programs, which was adopted by the FSMB’s House of Delegates and which directed the FSMB  
10                   to establish a task force to study PDMP use in the United States and its territories. The  
11                   Workgroup was charged with evaluating the impact of mandatory PDMP query on patient  
12                   outcomes and the prescribing of controlled substances; evaluating challenges to increasing  
13                   PDMP utilization, including, but not limited to: a) authority to access; b) currency of data; c)  
14                   Electronic Medical Record (EMR) integration; and d) interoperability; and developing  
15                   recommendations to state medical and osteopathic boards (hereafter referred to as “state medical  
16                   boards”) regarding physician utilization of PDMPs, including a recommendation regarding  
17                   mandatory query.  
18

19                   This document provides recommendations for state medical boards and other state agencies to  
20                   maximize the effective use of PDMPs.  
21

22                   In developing the recommendations that follow, the Workgroup conducted a review of PDMP  
23                   statutes, rules, and state medical board policies currently enacted across the United States,  
24                   research reports and peer-reviewed articles in the medical literature and policy statements  
25                   regarding the use of PDMP.

26 **Section 1. Background**

27  
28 Overdose deaths from prescription opioids in the United States quintupled between 1999-2016,  
29 totaling more than 200,000 deaths during that time. In 2016, more than 46 people died every day  
30 from overdoses involving prescription opioids.<sup>12</sup> This escalating public health epidemic has led  
31 to a wave of implementations and upgrades to states' prescription drug monitoring programs  
32 over the past decade in an effort to curb substance use disorder.

33  
34 State regulatory, administrative, and law enforcement agencies have long seen the need to  
35 establish systems to track and monitor the prescribing and dispensing of certain controlled  
36 substances, a recognition that dates to 1918.<sup>3</sup> California has the oldest continuous program,  
37 created in 1939. Early PDMPs were paper-based and collected data on Schedule II prescribing  
38 and dispensing only. Collected data was typically reported into such systems within 30 days of  
39 the time from dispensing.

40  
41 In 1990, a new era of electronic PDMPs broke ground when Oklahoma became the first state to  
42 require electronic transmission of such data, which helped reduce operational costs and increase  
43 accuracy and timely submissions. By 1992, 10 states had operational PDMPs and many other  
44 states were considering establishing their own. In 1995, Nevada became the first state to expand  
45 the type of drugs reported to the PDMP, expanding from Schedule II only to Schedules II-IV. At  
46 the same time, Nevada also became the first state to provide unsolicited reports back to  
47 prescribers. By 2000, 15 states had established PDMPs. Between 2000-2012, 34 additional states  
48 established such a program, bringing the total number to states with PDMPs to 49. In 2014, the  
49 District of Columbia established a PDMP, bringing the total of operational PDMPs to 49 states,  
50 plus D.C. and Guam. Puerto Rico has also enacted legislation creating a PDMP but it is not yet  
51 operational.

52  
53 As of September 2017, Missouri remains the only state without a statewide, operational PDMP.  
54 To work around this obstacle, St. Louis County established its own PDMP in March 2016 and,  
55 since then, this PDMP has gone live (as of April 2017) and more than 50 counties in the state and  
56 several individual cities have joined as participants, representing more than 70 percent of  
57 Missouri's population and 91 percent of its prescribers.<sup>4</sup> Separately, in July 2017, the Missouri  
58 governor issued an executive order to create a statewide PDMP that allows the Missouri  
59 Department of Health and Senior Services to analyze and identify inappropriate prescribing,  
60 dispensing, and obtaining of controlled substances, and to address these actions by making

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<sup>1</sup> Centers for Disease Control, Opioid Data Analysis. <https://www.cdc.gov/drugoverdose/data/analysis.html>

<sup>2</sup> Centers for Disease Control, Wide-ranging online data for epidemiologic research (WONDER). Atlanta, GA: CDC, National Center for Health Statistics; 2016. <http://wonder.cdc.gov>

<sup>3</sup> Blumenschein, Karen, et. al. "Review of Prescription Drug Monitoring Programs in the United States." Institute for Pharmaceutical Outcomes and Policy, University of Kentucky, June 2010. <http://chfs.ky.gov/NR/rdonlyres/85989824-1030-4AA6-91E1-7F9E3EF68827/0/KASPEREvaluationPDMPStatusFinalReport6242010.pdf>.

<sup>4</sup> St. Louis County Prescription Drug Monitoring Program, "PDMP Program Update." <http://www.stlouisco.com/Portals/8/docs/document%20library/PDMP/UPDATE-%20St.%20Louis%20County%20PDMP.pdf>

61 referrals to appropriate government officials, including law enforcement and professional  
62 licensing boards.<sup>5</sup>

63  
64 While the common goal of PDMPs is to provide prescribers and other health care professionals  
65 with accurate information about the prescriptions that patients have obtained, a state’s decision to  
66 apply comprehensive mandates varies widely. The differences between states relate to the types  
67 of drugs monitored and the types of prescribers who are mandated to query, as well as to the  
68 circumstances which necessitate querying the PDMP, among other differences.<sup>67</sup> For instance,  
69 some PDMPs monitor Schedules II-IV controlled substances, while others monitor Schedules II-  
70 V or certain non-controlled substances.<sup>8</sup> Thirty-six states and the District of Columbia mandate  
71 PDMP query under certain circumstances. Of those, 27 states require querying the PDMP during  
72 the initial prescribing of a designated substance, while nine states require querying the PDMP  
73 before each prescription of a designated substance. Twelve states mandate querying the PDMP  
74 when prescribing for the treatment of pain and 14 states require it when prescribing for drug  
75 addiction. Among those states requiring a prescriber to query the PDMP prior to the initial  
76 prescription of a designated substance, some only require it if it is a Schedule II or III opioid,  
77 while others require it only if the initial opioid prescription surpasses a seven-day supply.<sup>9</sup>

78  
79 This report aims to provide guidance to state medical boards about effective PDMP use, one of  
80 many strategies being recommended to address the growing prescription opioid epidemic.

81

## 82 **Section 2. Definitions**

83

84 *Mandatory Registration* – A state’s requirement that prescribers of controlled substances must  
85 register with the state’s PDMP.

86

87 *Prescription Drug Monitoring Program* – A patient safety tool designed to facilitate the  
88 collection, analysis, and reporting of information about the prescribing and dispensing of  
89 controlled substances.<sup>10</sup>

90

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<sup>5</sup> Missouri Executive Order. No. 17-18, 2018. <https://www.sos.mo.gov/library/reference/orders/2017/eo18>

<sup>6</sup> Blumenschein, Karen, et. al. “Review of Prescription Drug Monitoring Programs in the United States.” Institute for Pharmaceutical Outcomes and Policy, University of Kentucky, June 2010. <http://chfs.ky.gov/NR/rdonlyres/85989824-1030-4AA6-91E1-7F9E3EF68827/0/KASPEREvaluationPDMPStatusFinalReport6242010.pdf>.

<sup>7</sup> Wen, Hefei, et al. “States with Prescription Drug Monitoring Mandates Saw A Reduction in Opioids Prescribed to Medicaid Enrollees.” Health Affairs, vol. 36, no. 4, Apr. 2017, pp. 733–741., [www.ncbi.nlm.nih.gov/pubmed/28373340](http://www.ncbi.nlm.nih.gov/pubmed/28373340).

<sup>8</sup> “Substances Monitored by PMP.” National Alliance for Model State Drug Laws, May 2016, [www.namsdl.org/library/8D7261F8-E47D-B6A5-DD0CFA98FEA4846](http://www.namsdl.org/library/8D7261F8-E47D-B6A5-DD0CFA98FEA4846).

<sup>9</sup> “Mandated Use of State Prescription Drug Monitoring Programs: Highlights of Key State Requirements.” National Alliance for Model State Drug Laws, June 2017. <http://www.namsdl.org/library/6735895A-CA6C-1D6B-B8064211764D65D0/>

<sup>10</sup> Federation of State Medical Boards (FSMB). Model Policy for the Use of Opioid Analgesics in the Treatment of Chronic Pain. Washington, DC: The Federation, 2013.

91 *Universal Use* – A state’s requirement that prescribers must query the patient’s PDMP history  
92 before initially prescribing opioid pain relievers and benzodiazepines, and at certain intervals  
93 thereafter.<sup>11</sup>

94  
95 *Unsolicited Reports* – Proactive communications from the PDMP to prescribers, dispensers, law  
96 enforcement, and/or regulators to provide information about patient prescriptions and/or the  
97 prescribing activity of a health care professional based upon PDMP data.<sup>12</sup>

98

### 99 **3. Mandatory Registration**

100

101 Studies show that between 2010-2012, states with operational PDMPs saw an average  
102 registration rate of 35 percent among licensed prescribers who prescribed at least one controlled  
103 substance during that period.<sup>13</sup> In 2014, a national survey found that 53 percent of primary care  
104 physicians used their state’s PDMP at least once, but many were not using the PDMP on a  
105 routine basis.<sup>14</sup> Although there have been extensive educational campaigns to recruit prescribers  
106 to participate in their state’s PDMP, results have not always been successful.<sup>15</sup> At the same time,  
107 however, PDMP registration has increased significantly, increasing from approximately 471,000  
108 to more than 1.3 million from 2014 to 2016. During the same time period, queries by physicians  
109 and other health care professionals increased from approximately 61 million to more than 136  
110 million.<sup>16</sup>

111

112 States are seeing success in increasing prescriber PDMP registration rates through other  
113 methods, such as mandatory registration. Massachusetts took a staggered, low resource-intensive  
114 approach by linking PDMP enrollment to the renewal of state controlled substance registration,  
115 where renewals are required every three years for practitioners. The process established by  
116 Massachusetts allowed for a continuous workflow for PDMP staff, rather than a surge in  
117 applications immediately after the enactment of mandatory PDMP registration legislation. As a  
118 result, the state first saw a gradual increase in registration, followed by a more dramatic increase,  
119 between 2011-2016. In 2011 and 2012, only 1 percent and 2 percent of prescribers were  
120 registered with the PDMP, respectively. By the end of 2014, however, nearly 66 percent of  
121 prescribers were enrolled. By September 2015, that percentage increased to 83 percent, and by  
122 January 2016, more than 90 percent had enrolled.<sup>17</sup>

123

### 124 **4. Universal Use**

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<sup>11</sup> CDC Prevention Status Report, <https://wwwn.cdc.gov/psr/NationalSummary/NSPDO.aspx>

<sup>12</sup> The PEW Charitable Trusts, *Prescription Drug Monitoring Programs: Evidence-Based Practices to Optimize Prescriber Use*, December 2016. [www.pewtrusts.org/en/research-and-analysis/reports/2016/12/prescription-drug-monitoring-programs](http://www.pewtrusts.org/en/research-and-analysis/reports/2016/12/prescription-drug-monitoring-programs).

<sup>13</sup> Wen, Hefei, et al. “States with Prescription Drug Monitoring Mandates Saw A Reduction in Opioids Prescribed to Medicaid Enrollees.” *Health Affairs*, vol. 36, no. 4, Apr. 2017, pp. 733–741., [www.ncbi.nlm.nih.gov/pubmed/28373340](http://www.ncbi.nlm.nih.gov/pubmed/28373340).

<sup>14</sup> Ibid.

<sup>15</sup> Ibid.

<sup>16</sup> Survey of state PDMP administrators. American Medical Association.

<sup>17</sup> The PEW Charitable Trusts, *Prescription Drug Monitoring Programs: Evidence-Based Practices to Optimize Prescriber Use*, December 2016. [www.pewtrusts.org/en/research-and-analysis/reports/2016/12/prescription-drug-monitoring-programs](http://www.pewtrusts.org/en/research-and-analysis/reports/2016/12/prescription-drug-monitoring-programs).

125  
126 Research shows that between 2011-2014, 85 percent of states that implemented some form of a  
127 PDMP universal use mandate were based upon legislation that was of limited scope and strength.  
128 Due to the weakness of the mandates in these cases, it is unlikely that they will prove effective in  
129 improving opioid prescribing practices.<sup>18</sup> Efforts to strengthen universal use mandates are  
130 supported by President Donald Trump’s Commission on Combating Drug Addiction and the  
131 Opioid Crisis, which recommends that federal agencies mandate PDMP querying.<sup>19</sup>

132  
133 States that have established an effective PDMP, in part or in whole, employ certain evidence-  
134 based practices. These practices include delegated authority, unsolicited reports, data timeliness,  
135 streamlined enrollment, educational initiatives, integration and data sharing, enhanced user  
136 interfaces, and proper funding, with delegated authority, data timeliness, and integration and data  
137 sharing being critical elements.<sup>20</sup>

138  
139 *Delegated Authority*  
140 Prescription Drug Monitoring Programs can serve as valuable tools to help inform prescribers’  
141 decision making and identify potential substance use disorder, but a significant barrier to  
142 increasing prescriber use of them is the time typically needed to query the system.<sup>21</sup> To decrease  
143 the time spent by prescribers reviewing patient records, many states authorize registered users to  
144 delegate non-prescriber employees the ability to access the system using sub-accounts. States  
145 vary, however, in whether a delegate has to be a licensed individual or not, as well as in the  
146 number of prescriber delegates permissible. Currently, 47 states and the District of Columbia  
147 authorize prescribers to delegate such authority, with 36 states actively doing so.<sup>22</sup> Some states  
148 only permit two delegates per prescriber, while others impose no limits.<sup>23</sup>

149  
150 In Kentucky, the state’s PDMP, known as the Kentucky All Schedule Prescription Electronic  
151 Reporting Program (KASPER), does not restrict the number of subaccounts to licensed staff.  
152 Prescribers also have no limit on the number of designated delegates, who are also permitted to  
153 serve as a delegate for multiple prescribers. For prescribers sharing multiple delegates, delegates  
154 are able to select the prescriber from a dropdown list to accurately record for which prescriber a

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<sup>18</sup> Wen, Hefei, et al. “States with Prescription Drug Monitoring Mandates Saw A Reduction in Opioids Prescribed to Medicaid Enrollees.” *Health Affairs*, vol. 36, no. 4, Apr. 2017, pp. 733–741., [www.ncbi.nlm.nih.gov/pubmed/28373340](http://www.ncbi.nlm.nih.gov/pubmed/28373340).

<sup>19</sup> The President’s Commission on Combating Drug Addiction and the Opioid Crisis, “Final Report,” 15 November 2017. [https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Final\\_Report\\_Draft\\_11-15-2017.pdf](https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Final_Report_Draft_11-15-2017.pdf)

<sup>20</sup> The PEW Charitable Trusts, *Prescription Drug Monitoring Programs: Evidence-Based Practices to Optimize Prescriber Use*, December 2016. [www.pewtrusts.org/en/research-and-analysis/reports/2016/12/prescription-drug-monitoring-programs](http://www.pewtrusts.org/en/research-and-analysis/reports/2016/12/prescription-drug-monitoring-programs).

<sup>21</sup> Rutkow, L. et al. “Many primary care physicians are aware of prescription drug monitoring programs, but many find the data difficult to access.” *Health Affairs*, vol. 34, no. 3, March 2015, pp. 484-492., <http://www.healthaffairs.org/doi/full/10.1377/hlthaff.2014.1085>

<sup>22</sup> Brandeis University PDMP Training and Technical Assistance Center. “PDMPs Authorized and Engaged in Sending Solicited and Unsolicited Reports to Health Care Providers and Patients.” [http://www.pdmpassist.org/pdf/Health\\_Care\\_Entity\\_Table\\_20170824.pdf](http://www.pdmpassist.org/pdf/Health_Care_Entity_Table_20170824.pdf)

<sup>23</sup> The PEW Charitable Trusts, *Prescription Drug Monitoring Programs: Evidence-Based Practices to Optimize Prescriber Use*, December 2016. [www.pewtrusts.org/en/research-and-analysis/reports/2016/12/prescription-drug-monitoring-programs](http://www.pewtrusts.org/en/research-and-analysis/reports/2016/12/prescription-drug-monitoring-programs).

155 report is being queried. The prescriber is responsible for deactivating accounts of delegates who  
156 leave the practice or otherwise warrant discontinuance of PDMP access. Delegates are permitted  
157 to conduct queries and provide reports for prescriber review, but are prohibited from conducting  
158 the clinical review of data that the state’s mandate requires. As a result of allowing such  
159 delegated authority, during the fourth quarter of 2015 delegates requested nearly 64 percent of  
160 in-state prescriber reports, despite accounting for 42 percent of combined delegate and prescriber  
161 master accounts by the end of that year.<sup>24</sup>

162  
163 *Unsolicited Reports*

164 PDMPs provide prescription history reports to authorized users upon request (these are also  
165 known as “solicited” reports), but when these reports are not requested useful information can go  
166 unseen or unused by prescribers. In an effort to increase utilization, many PDMPs proactively  
167 send “unsolicited” (and, therefore, unrequested) reports to specific prescribers, dispensers, state  
168 licensing boards, and law enforcement agencies that contain data suggestive, or indicative, of  
169 multiple provider episodes or inappropriate prescribing and dispensing.<sup>25</sup>

170  
171 In 2005, Maine began sending prescribers quarterly threshold notification reports via U.S. mail,  
172 but in 2013 moved to monthly emailed alerts. Originally, these alerts were sent to registered  
173 PDMP users only when one of three criteria was met by a patient: 1) exceeds a certain number of  
174 prescribers and pharmacies in a three-month period; 2) exceeds a specified average daily dose of  
175 acetaminophen coming from prescriptions of opioid-acetaminophen combination drugs; or 3) is  
176 prescribed buprenorphine and another opioid in a 30-day period. In 2015, however, the state’s  
177 legislature added two new criteria to initiate alerts: 1) multiple overlapping prescriptions for  
178 medications containing opioids; and 2) prescriptions for more than 300 morphine milligram  
179 equivalents daily for more than 45 consecutive days within a 90 day period. Alert recipients must  
180 log into their PDMP account to review the patient’s prescription history, which includes the  
181 other providers who prescribed to the patient, the pharmacies that dispensed to the patient, drugs  
182 and quantities and other details of prescriptions dispensed for the past three months.

183 Additionally, the state recently enabled prescribers to request reports based on their own set  
184 thresholds. It is believed that unsolicited reports may have affected prescriber behavior from  
185 2010 to 2014 when the state saw a steady decline in the rate of multiple provider episodes.<sup>26</sup>

186  
187 Additionally, in Indiana, a prescriber who believes a patient’s PDMP data suggests questionable  
188 activity has the option to send email alerts to other prescribers and dispensers of the patient.  
189 These “user-led unsolicited report” email alerts do not contain a patient’s name or any  
190 conclusions, but rather contains a hyperlink to a patient’s prescription history report that  
191 registered users can review after logging into the PDMP, thus ensuring Health Insurance  
192 Portability and Accountability Act (HIPAA) compliance. These alerts serve to notify prescribers  
193 and dispensers that a patient may be using unnecessary prescription drugs, may be receiving  
194 controlled substances from multiple providers, or may be involved in controlled substance

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<sup>24</sup> Ibid.

<sup>25</sup> Brandeis University PDMP Training and Technical Assistance Center, “Guidance on PDMP Best Practices: Options for Unsolicited Reporting,” May 2016.

[http://www.pdmpassist.org/pdf/COE\\_documents/Add\\_to\\_TTAC/Update%20to%20Brandeis%20COE%20Guidance%20on%20Unsolicited%20Reporting%20final.pdf](http://www.pdmpassist.org/pdf/COE_documents/Add_to_TTAC/Update%20to%20Brandeis%20COE%20Guidance%20on%20Unsolicited%20Reporting%20final.pdf)

<sup>26</sup> Ibid.

195 diversion. Indiana first launched its user-led unsolicited reports in March 2012. After the first  
196 three months of the program, 140 practitioners had sent 2,284 alerts on 214 unique patients, at  
197 virtually no cost to the program.<sup>27</sup>

198

### 199 *Data timeliness*

200 A prescriber's ability to effectively use PDMP data to assess a patient's prescription history can  
201 only be as complete as the data that is transmitted into the system by a dispenser. If a PDMP  
202 report does not contain information about the most recently dispensed controlled substances, a  
203 prescriber may lack valuable data to determine the best course of treatment. Because of this, it is  
204 imperative to minimize the pharmacy reporting interval. States are increasingly moving away  
205 from weekly reporting towards daily PDMP data reporting. In 2015, 24 states required daily data  
206 submissions. As of July 2017, 40 states and the District of Columbia required data to be reported  
207 within 24 hours or one business day. Oklahoma is the only state currently requiring real-time  
208 reporting,<sup>28</sup> but the transition from daily reporting to real-time required two years and involved  
209 intensive effort and overtime for the PDMP, as well as redesign for pharmacy data systems and  
210 workflow procedures.<sup>29</sup>

211

### 212 *Streamlined Enrollment*

213 In order to access PDMP data, prescribers must typically establish online accounts with a state's  
214 PDMP system. This process requires the prescriber to submit, and the PDMP to verify,  
215 identifying information, such as name, date of birth, state controlled substance prescribing or  
216 medical practice license number, DEA registration number, driver's license number, place of  
217 employment, medical specialty, and contact information. Once the prescriber's state controlled  
218 substance prescribing or medical practice license number and a DEA registration number is  
219 verified, the prescriber may create an account and begin to query patients' controlled substance  
220 prescription history. Unfortunately for many prescribers, the process can be time consuming to  
221 complete registration applications as some states require paper applications and notarization.<sup>30</sup>  
222 To expedite PDMP registration, and to transition away from paper applications, some states  
223 began migrating to an online registration system, in addition to automatic prescriber enrollment,  
224 during initial medical licensure and licensure renewal.

225

226 In 2012, the Tennessee Legislature enacted legislation mandating that prescribers use the state's  
227 PDMP and dispensers register. The comprehensive mandate required DEA-registered prescribers  
228 and dispensers to register with the PDMP within the first eight months after the law's enactment.  
229 New licensees are required to register with the PDMP within 30 days. The universal use mandate  
230 went into effect four months after prescribers and dispensers were required to register. In an

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<sup>27</sup> Indiana Scheduled Prescription Electronic Collection & Tracking (INSPECT). "Presentation on User-Led Unsolicited Reporting (ULUR)." 2012.

[http://www.pdmpassist.org/pdf/PPTs/National2012/2\\_Allain\\_StatePanelInnovationsIndiana.pdf](http://www.pdmpassist.org/pdf/PPTs/National2012/2_Allain_StatePanelInnovationsIndiana.pdf)

<sup>28</sup> National Alliance for Model State Drug Laws, "Frequency of Prescription Drug Monitoring Program Data," 30 June 2017. <http://www.namsdl.org/library/03B95893-0EE2-3766-EABAD212B5C8E8D3/>

<sup>29</sup> The PEW Charitable Trusts, *Prescription Drug Monitoring Programs: Evidence-Based Practices to Optimize Prescriber Use*, December 2016. [www.pewtrusts.org/en/research-and-analysis/reports/2016/12/prescription-drug-monitoring-programs](http://www.pewtrusts.org/en/research-and-analysis/reports/2016/12/prescription-drug-monitoring-programs).

<sup>30</sup> The Network for Excellence in Health Innovation, "Issue Brief – Physicians and PDMPs: Improving the Use of Prescription Drug Monitoring Programs," November 2015.

[https://www.nehi.net/writable/publication\\_files/file/pdmp\\_issue\\_brief\\_11.18.pdf](https://www.nehi.net/writable/publication_files/file/pdmp_issue_brief_11.18.pdf)

231 effort to handle the influx of registrations, Tennessee adopted an online registration system. This  
232 system automatically attempts to validate a prescriber’s information using electronic databases  
233 for the state’s professional health care licenses, driver’s licenses, and DEA prescriber  
234 registration. For prescribers who do not have health care licenses or DEA numbers, such as  
235 medical residents in hospitals in some states, PDMP registration is still processed manually. As a  
236 result of the streamlined online registration system for licensed prescribers and dispensers, the  
237 number of registered prescribers has increased 127 percent between 2011 (a year before the  
238 mandate went into effect) and 2014. Additionally, average queries per month have increased 203  
239 percent during that same time period.<sup>31</sup>

240

#### 241 *Educational Initiatives*

242 Many state medical boards require physicians to complete continuing medical education (CME)  
243 in specific content areas, such as pain management and controlled substance prescribing  
244 practices. Thirty-two of the 50 states, and the District of Columbia, mandate at least one content-  
245 specific CME course. Of those 32 states, 29 states require CME focused on either pain  
246 management or controlled substance prescribing practices, or in some circumstances both. In 26  
247 out of those 29 states, the CME requirements are for both allopathic and osteopathic physicians.  
248 In two states, Oklahoma and Nevada, only osteopathic physicians are required to complete CME  
249 on pain management/controlled substance prescribing practices, while in Vermont only  
250 allopathic physicians are required to complete such CME. Additionally, 12 of the 29 states  
251 require CME on pain management/controlled substance prescribing practices for all physicians,  
252 while the other 17 states only require a subset of physicians to complete such requirements, such  
253 as controlled substance providers or certain providers who work in pain clinics.<sup>32</sup>

254

255 In order to assist prescribers in completing CME requirements, as well as educate prescribers  
256 who are not required to complete content-specific CME, the federal government promotes  
257 certain educational initiatives. The U.S. Department of Health and Human Service’s (HHS)  
258 Substance Abuse and Mental Health Services Administration (SAMHSA) and the Health  
259 Resources and Services Administration (HRSA) jointly developed the “Substance Use  
260 Trainings” webpage as an online educational resource that provides one-time and ongoing  
261 training activities dedicated to pain management and controlled substance prescribing practices.  
262 HHS’s Office of Disease Prevention and Health Promotion also developed an online education  
263 resource, *Pathways to Safer Opioid Use*, while the U.S. Food and Drug Administration’s (FDA)  
264 Risk Evaluation and Mitigation Strategy (REMS) for extended release/long-acting opioids  
265 requires CME to be offered by opioid manufacturers.<sup>33</sup> As part of REMS, the FDA released the  
266 *FDA Blueprint for Prescriber Education for Extended-Release and Long-Acting Opioid*  
267 *Analgesics*, which contains core educational messages for the development of continuing

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<sup>31</sup> The PEW Charitable Trusts, *Prescription Drug Monitoring Programs: Evidence-Based Practices to Optimize Prescriber Use*, December 2016. [www.pewtrusts.org/en/research-and-analysis/reports/2016/12/prescription-drug-monitoring-programs](http://www.pewtrusts.org/en/research-and-analysis/reports/2016/12/prescription-drug-monitoring-programs).

<sup>32</sup> Xu, Jing, PhD, MA; Gribble, Anna, MSW, MPH, et al. “State Continuing Education Requirements for Physicians and Dentists, Including Requirements Related to Pain Management and Controlled Substance Prescribing,” *Journal of Medical Regulation*, Vol. 103, Number 3, 2017.

<sup>33</sup> *Ibid.*

268 education activities focused on safe prescribing.<sup>34</sup> The Centers for Disease Control (CDC) also  
269 provides educational materials, such as *Applying CDC's Guideline for Prescribing Opioids: An*  
270 *Online Training Series for Providers* and *What Healthcare Providers Need to Know About*  
271 *PDMPs*.<sup>35,36</sup>

272  
273 While a majority of states require physicians to complete certain content-specific CME, FSMB  
274 policy states that, “the FSMB believes mandatory continuing medical education is a matter  
275 reserved for the individual state jurisdictions.”<sup>37</sup>

276  
277 *Integration and Data Sharing*  
278 The value of PDMP data is based in part on whether such data is readily available and accessible.  
279 Although PDMPs collect controlled substance prescription information in a central repository,  
280 the adoption and utilization of a PDMP by prescribers is slowed when such data is not integrated  
281 into health information technology (HIT) systems, specifically electronic health records (EHR).

282  
283 There have been several efforts and initiatives to spur the pace at which PDMP data is integrated,  
284 such as SAMHSA’s PDMP Electronic Health Records Integration and Interoperability  
285 Expansion (PEHRIIE) program, which funded projects in nine states from 2012-2016. The goal  
286 of this program was to increase prescriber utilization by integrating PDMP data into HITs. The  
287 program also sought to increase the comprehensiveness of PDMP data by increasing interstate  
288 PDMP data sharing.<sup>38</sup>

289  
290 Programs such as PEHRIIE demonstrate the effectiveness of integrating PDMP data into HITs.  
291 During the fourth quarter of 2014, the state of Washington became interoperable with  
292 OneHealthPort, a statewide HIE, enabling integration with the Emergency Department  
293 Information Exchange (EDIE), a hub connecting hospital emergency departments. In 2015, the  
294 first full calendar year after integration, the PDMP provided 2,222,446 solicited reports to  
295 prescribers, compared to 2014, when 26,546 solicited reports were provided to prescribers.<sup>39</sup>  
296 Significant increases in solicited reports were also experienced in Kansas after PDMP data was  
297 integrated with the Via Christi Health Network, the largest healthcare provider in Kansas, in late  
298 2013. After integration, solicited reports provided to Via Christi prescribers increased from  
299 31,156 reports in 2013 to 223,000 reports in 2015. Compared to other prescribers in Kansas, the  
300 number of solicited reports increased significantly less, from 23,171 in 2013 to 65,242 in 2015.  
301

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<sup>34</sup> United States Food and Drug Administration, *Introduction for the FDA Blueprint for Prescriber Education for Extended-Release and Long-Acting Opioid Analgesics*, May 2017.

<https://www.fda.gov/downloads/Drugs/DrugSafety/InformationbyDrugClass/UCM515636.pdf>

<sup>35</sup> Centers for Disease Control, *Applying CDC's Guideline for Prescribing Opioids: An Online Training Series for Provider*. <https://www.cdc.gov/drugoverdose/training/overview/index.html>

<sup>36</sup> Centers for Disease Control, *What Healthcare Providers Need to Know About PDMPs*.

<https://www.cdc.gov/drugoverdose/pdmp/providers.html>

<sup>37</sup> Federation of State Medical Boards (FSMB), *FSMB Policy 100.2, Mandating Continuing Medical Education*, Washington, DC: The Federation, 1980.

<sup>38</sup> Centers for Disease Control (CDC). “Integrating & Expanding Prescription Drug Monitoring Program Data: Lessons from Nine States,” February 2017. [https://www.cdc.gov/drugoverdose/pdf/pehriie\\_report-a.pdf](https://www.cdc.gov/drugoverdose/pdf/pehriie_report-a.pdf)

<sup>39</sup> Ibid.

302 Several states also announced efforts to integrate prescription drug information into EHRs and  
303 other HITs. In August 2017, Indiana announced that it would integrate PDMP data into EHRs at  
304 hospitals and physician practices across the state at no cost to the facility or individual  
305 practitioner. The phased-in integration is scheduled to be completed by 2020.<sup>40</sup> Michigan also  
306 announced in June 2017 that state and federal funds will be invested over a two year period to  
307 integrate the state’s PDMP, Michigan Automated Prescription System, into EHRs and pharmacy  
308 dispensation systems.<sup>41</sup> Additionally, Arizona, Kansas, Massachusetts, Ohio, Pennsylvania, and  
309 Virginia are supporting integration into EHRs, HITs, and pharmacy dispensing systems at no  
310 cost.

311  
312 These recent state trends to integrate PDMP data are in line with recommendations being  
313 conveyed at the federal level, including the President’s Commission on Combating Drug  
314 Addiction and the Opioid Crisis, which recommended in November 2017 that “PDMP data  
315 integration with electronic health records, overdose episodes, and substance use disorder-related  
316 decision support tools for providers is necessary to increase effectiveness.”<sup>42</sup>

317  
318 The ability for prescribers to view prescription drug history information across state lines can  
319 assist in identifying a potential substance use disorder. To facilitate interstate PDMP data sharing  
320 and integration, states have opted to connect to a data sharing hub. Forty-five states and the  
321 District of Columbia are currently engaged in some form of interstate data sharing, while three  
322 other states are in the process of implementing data sharing.<sup>43</sup> Not all states, however, allow  
323 universal data sharing among states. Some states allow prescribers in any state to access PDMP  
324 data, while other states allow prescribers from specific states within a region. These are usually  
325 in-state policy decisions that often change to expand toward a goal of universal access.

326  
327 The President’s Commission on Combating Drug Addiction and the Opioid Crisis also  
328 recommended supporting federal legislation mandating states that receive grant funds to comply  
329 with PDMP requirements, including data sharing, and establishing and maintaining a data-  
330 sharing hub.<sup>44</sup>

331  
332 In an effort to reduce barriers to data sharing across state lines, there have been various data  
333 sharing hubs launched to facilitate data sharing in compliance with each state’s data access  
334 regulations. At the request of several PDMPs, the National Association of Boards of Pharmacy  
335 (NABP) created Prescription Monitoring Program (PMP) InterConnect in 2011. PMP  
336 InterConnect provides for encrypted data to be transmitted across state lines. To date, 45 states  
337 have executed a memorandum of understanding (MOU) with NABP to participate and 42 of

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<sup>40</sup> Sweeney, Evan, “Indiana announces plans to integrate PDMP data into EHRs across the state,” FierceHealthcare, 25 August 2017. <https://www.fiercehealthcare.com/ehr/indiana-announces-plans-to-integrate-pdmp-data-into-ehrs-across-state>

<sup>41</sup> Office of Governor Rick Snyder, “Patient Protections Strengthened as State Fully Integrates MAPS into Health Systems,” 19 June 2017. [http://www.michigan.gov/snyder/0,4668,7-277-73341\\_73343-424218--,00.html](http://www.michigan.gov/snyder/0,4668,7-277-73341_73343-424218--,00.html)

<sup>42</sup> The President’s Commission on Combating Drug Addiction and the Opioid Crisis, *Final Report*, 15 November 2017. [https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Final\\_Report\\_Draft\\_11-15-2017.pdf](https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Final_Report_Draft_11-15-2017.pdf)

<sup>43</sup> Brandeis University PDMP Training and Technical Assistance Center, “Interstate Data Sharing,” 20 September 2017. [http://www.pdmpassist.org/pdf/Interstate\\_Data\\_Sharing\\_20170920.pdf](http://www.pdmpassist.org/pdf/Interstate_Data_Sharing_20170920.pdf)

<sup>44</sup> The President’s Commission on Combating Drug Addiction and the Opioid Crisis, “Final Report,” 15 November 2017. [https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Final\\_Report\\_Draft\\_11-15-2017.pdf](https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Final_Report_Draft_11-15-2017.pdf)

338 those states are now live. Each month, PMP InterConnect processes more than 15 million  
339 requests.<sup>45</sup>

340  
341 Separately, RxCheck is another data sharing hub that was created with support from the U.S.  
342 Bureau of Justice Assistance (BJA) and using the Prescription Monitoring Information Exchange  
343 (PMIX) National Architecture specifications. As of July 2017, there are four states that are  
344 engaged in interstate data sharing with RxCheck, while two states are currently implementing  
345 interstate data sharing and eight states have plans to connect to RxCheck.

#### 346 *Enhanced User Interfaces*

347 While having access to PDMP data is integral for prescribers, it is equally important that  
348 prescribers are able to quickly analyze and use that data. As the amount of controlled substance  
349 prescription information available to prescribers has increased in recent years, prescribers have  
350 sought ways to quickly analyze the most important information for clinical decision making. To  
351 address this, states began exploring ways to better interpret the data. Some of these methods  
352 included adding an enhanced user interface to the PDMP system that includes, but is not limited  
353 to, a total morphine milligram equivalent (MME) calculation for each opioid prescription, a daily  
354 MME dose level, and flags or alerts if a patient's MME surpasses a certain threshold.<sup>46</sup>

355  
356 In 2016, the California PDMP, Controlled Substance Utilization Review and Evaluation System  
357 (CURES) underwent a redesign to help prescribers improve their clinical decision-making when  
358 evaluating whether to prescribe a controlled substance. The new updated program contains a  
359 dashboard that provides users patient alerts, including a list of patients who are prescribed more  
360 than 100 MME per day; have obtained prescriptions from six or more prescribers or pharmacies  
361 during the past 12 months; are prescribed more than 40 milligrams of methadone daily; have  
362 been prescribed opioids for more than 90 consecutive days; or are concurrently prescribed  
363 benzodiazepines and opioids.<sup>47</sup>

364  
365 Enhanced user interfaces are a recent development and, as such, there is a paucity of evidence on  
366 its effectiveness in identifying a potential substance use disorder or coordinating care in the case  
367 of a multiple provider event.

#### 368 *Data Security/Patient Protections*

369 As the use of PDMP increases nationwide and controlled substances prescription history is  
370 increasingly used by prescribers, patients are increasingly concerned about the security of their  
371 data and the possibility of law-enforcement scrutiny. Prescribers are also increasingly concerned  
372  
373

---

<sup>45</sup> National Association of Boards of Pharmacy, "Connecting State Prescription Monitoring Programs Nationwide," November 2017. <https://nabp.pharmacy/wp-content/uploads/2017/11/NABP-InterConnect-Flyer-November-2017.pdf>

<sup>46</sup> The PEW Charitable Trusts, *Prescription Drug Monitoring Programs: Evidence-Based Practices to Optimize Prescriber Use*, December 2016. [www.pewtrusts.org/en/research-and-analysis/reports/2016/12/prescription-drug-monitoring-programs](http://www.pewtrusts.org/en/research-and-analysis/reports/2016/12/prescription-drug-monitoring-programs).

<sup>47</sup> California Department of Justice, "CURES 2.0: Prescription Drug Monitoring Program" (presentation September 2015). [https://www.sfhfp.org/files/providers/Best\\_Practices/CURES\\_2.0\\_PPT.pdf](https://www.sfhfp.org/files/providers/Best_Practices/CURES_2.0_PPT.pdf)

374 that medical consultations are no longer a private affair and that staff access pose the potential  
375 for unscrupulous use and data leaking.<sup>48</sup>

376  
377 Substance use disorder is a multifaceted problem and often requires collaboration among various  
378 agencies and stakeholders. PDMPs are primarily used as a public health tool, but law  
379 enforcement agencies see PDMPs as a potential law enforcement tool. An increase in law  
380 enforcement scrutiny of PDMP data may significantly affect a prescriber's clinical decision  
381 making and cause a prescriber to under prescribe.<sup>49</sup>

382  
383 A balanced approach between patient safety and data protection has been encouraged by various  
384 stakeholders. Both the American Medical Association (AMA) and the American Society of  
385 Addiction Medicine (ASAM) believe that PDMP data should be considered protected health  
386 information, and should not be released outside of the health care system unless there is  
387 authorization for release from the individual patient. The AMA also supports access to PDMP  
388 data via a warrant, as well as when the public safety demands in certain situations.<sup>50,51</sup>

389  
390 The United States District Court for the District of Oregon, Portland Division affirmed the limits  
391 of law enforcement access in February 2014 in *Oregon Prescription Drug Monitoring Program*  
392 *v. United States Drug Enforcement Administration*. The Court found that federal drug  
393 investigators cannot access patients' prescription information without proving probable cause  
394 and obtaining a warrant. The Court also found that administrative subpoenas are insufficient to  
395 demand information relevant to investigations into potential drug violations, such as a doctor  
396 who improperly prescribes drugs.<sup>52</sup> In June 2017, the United States Court of Appeals for the  
397 Ninth Circuit reversed the ruling as it found that requiring a court order to enforce the subpoena  
398 on the DEA interfered with Congress' intent to strengthen law enforcement tools against the  
399 traffic of illicit drugs. It recognized, however, that medical records require strong legal  
400 safeguards.<sup>53</sup>

401  
402 In Georgia, in addition to authorizing prescribers and dispensers, and their designated delegates,  
403 the Georgia Drugs and Narcotics Agency is authorized to provide requested prescription  
404 information collected to a patient, or the patient's attorney; local or state law enforcement or

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<sup>48</sup> Islam, M Mofizul and McRae, Ian S, "An inevitable wave or prescription drug monitoring programs in the context of prescription opioids: pros, cons and tensions," BMC Pharmacology & Toxicology, 6 August 2014.

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4138942/>

<sup>49</sup> Ibid.

<sup>50</sup> American Society of Addiction Medicine, "Public Policy Statement on Measures to Counteract Prescription Drug Diversion, Misuse and Addiction," 25 January 2012. <https://www.asam.org/advocacy/find-a-policy-statement/view-policy-statement/public-policy-statements/2012/01/26/measures-to-counteract-prescription-drug-diversion-misuse-and-addiction>

<sup>51</sup> American Medical Association, "Prescription Drug Monitoring Program Confidentiality H-95.946, 2015.

<https://policysearch.ama-assn.org/policyfinder/detail/prescription%20drug%20monitoring%20program?uri=%2FAMADoc%2FHOD.xml-0-5325.xml>

<sup>52</sup> *Oregon Prescription Drug Monitoring Program v. US Drug Enforcement Administration*, 998 F.Supp.2d 957 (2014) <https://www.leagle.com/decision/infcco20140212990>.

<sup>53</sup> *Oregon Prescription Drug Monitoring Program v. US Drug Enforcement Administration*, 860 F.3d 1228 (2017) <https://www.leagle.com/decision/infcco20170626117>

405 prosecutorial officials pursuant to the issuance of a search warrant from an appropriate court or  
406 official in the county in which the office of such law enforcement or prosecutorial officials are  
407 located or to federal law enforcement or prosecutorial officials pursuant to the issuance of a  
408 search warrant or a grand jury subpoena; to the Georgia Drugs and Narcotics Agency, the  
409 Georgia Composite Medical Board or any other state regulatory board governing prescribers or  
410 dispensers in this state, or the Department of Community Health for purposes of the state  
411 Medicaid program upon the issuance of a subpoena by such agency, board, or department  
412 pursuant to their existing subpoena power or to the federal Centers for Medicare and Medicaid  
413 Services upon the issuance of a subpoena by the federal government pursuant to its existing  
414 subpoena powers.<sup>54</sup>

415  
416 *Proper Funding*

417 To continually maintain and update a state's PDMP system often comes with a certain level of  
418 financial need. It is often difficult, however, for states to properly fund such operations and  
419 projects. In order to meet these demands, states use a wide variety of funding mechanisms,  
420 whether in whole or in part, including state appropriations, registration and licensing fees, and  
421 federal grants.

422  
423 One source of funding for states has been legislative appropriations and state government  
424 funding. In October 2015, Ohio Governor John Kasich announced that the state would invest up  
425 to \$1.5 million a year to integrate the Ohio Automated Rx Reporting System (OARRS) directly  
426 into electronic medical records and pharmacy dispensing systems across the state, allowing  
427 instant access for prescribers and pharmacists.<sup>55</sup>

428  
429 In addition to licenses to practice medicine, several states require a controlled substance  
430 prescribing license that is separate from DEA registration. The registration fees from these state  
431 prescribing licenses frequently go to support the PDMP, whether in full or in part. This funding  
432 mechanism assesses a fee on a subset of providers while the more current thinking is that all  
433 licensed providers should have access to their patients' PDMP data.<sup>56</sup>

434  
435 Instead of allocating funds from a specific controlled substance prescribing license, some states  
436 allocate a certain percentage from all professional licensing fees to go towards the state's PDMP.  
437 Although this avenue provides consistent funding, it is limited in dollar amount and increasing  
438 the allocated percentage may affect other operations of the Board.<sup>5758</sup>

439  
440 States often leverage federal grants to fund and maintain PDMP projects, as well. Since 2003, the  
441 U.S. Department of Justice's Bureau of Justice Assistance has administered the Harold Rogers  
442 PDMP Grant Program to reduce opioid misuse and the number of overdose fatalities by

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<sup>54</sup> Ga. Code § 16-13-30

<sup>55</sup> Ohio Automated Rx Reporting System, <https://wholesale.ohiopmp.gov/Portal/Integration.aspx>

<sup>56</sup> PDMP TTAC, "Funding Options for Prescription Drug Monitoring Programs," 3 July 2013.

[http://www.pdmpassist.org/pdf/PDMP\\_Funding\\_Options\\_TAG.pdf](http://www.pdmpassist.org/pdf/PDMP_Funding_Options_TAG.pdf)

<sup>57</sup> Brandeis University PDMP Training and Technical Assistance Center, "Funding Options for Prescription Drug Monitoring Programs," 3 July 2013. [http://www.pdmpassist.org/pdf/PDMP\\_Funding\\_Options\\_TAG.pdf](http://www.pdmpassist.org/pdf/PDMP_Funding_Options_TAG.pdf)

<sup>58</sup> National Alliance for Model State Drug Laws, "Funding Provisions of PDMPs," May 2016.

<http://www.namsdl.org/library/57555C8D-B77F-0F68-987334839CA29924/>

443 supporting the implementation, enhancement, and proactive use of state PDMPs. For Fiscal Year  
444 2017, two-year grants were awarded to 10 states and Puerto Rico totaling \$3,966,932.<sup>59</sup> The  
445 CDC also provides funding opportunities to support states' efforts to enhance and maximize  
446 PDMPs, including the Data Driven Prevention Initiative (DDPI) and Prevention for States (Pfs)  
447 Funding Opportunity Announcements.<sup>60</sup><sup>61</sup> Additionally, SAMHSA also provides a variety of  
448 funding opportunities for states to enhance their PDMPs.<sup>62</sup>

449

## 450 **5. Recommendations**

451

### 452 1. Mandatory Registration –

453 States should require PDMP registration for prescribers of controlled substances. This  
454 registration should take place at the time of the prescriber's initial medical licensure  
455 application or next renewal. In an effort to expedite the process, state PDMPs should  
456 facilitate online registration to meet the expected increase in applications.

457

### 458 2. Universal Use of PDMPs–

459 States should require universal use of PDMPs if the state's PDMP contains certain  
460 characteristics. Ideally, all the characteristics listed below would be present within a  
461 state's PDMP system but some are more critical than others to the functionality of the  
462 PDMP.

463

#### 464 a. Group 1: Critical Characteristics Needed for an Effective PDMP

465

##### 466 i. Delegation –

467 Each prescriber should be permitted to delegate authority to access the  
468 PDMP to any member of their health care team by creating subaccounts  
469 without limitations. Delegates should be able to be shared by multiple  
470 providers, such as a physician group or emergency department or similar  
471 setting. The prescriber must have the authority to deactivate a delegate's  
472 subaccount for any reason, including, but not limited to, leaving the practice  
473 or no longer serving in that capacity.

474

475 In order to ensure delegate accountability, prescribers must be allowed to  
audit their delegates' activity and use of the PDMP.

---

<sup>59</sup> U.S. Department of Justice, Bureau of Justice Assistance, Harold Rogers PDMP Grant Program,  
<https://www.bja.gov/funding/Category-5-awards.pdf>

<sup>60</sup> Centers for Disease Control, *Data Driven Prevention Initiative*.  
<https://www.cdc.gov/drugoverdose/foa/ddpi.html>

<sup>61</sup> Centers for Disease Control, *Prevention for States*.  
[https://www.cdc.gov/drugoverdose/states/state\\_prevention.html](https://www.cdc.gov/drugoverdose/states/state_prevention.html)

<sup>62</sup> Substance Abuse and Mental Health Services Administration. Grants Related to Prescription Drug Misuse and Abuse. <https://www.samhsa.gov/prescription-drug-misuse-abuse/grants>

476 ii. Data timeliness/accuracy –  
477 State PDMPs should require daily reporting of controlled substance  
478 prescription. Although it may be ideal to have real-time reporting, there is a  
479 paucity of data at this time to support it.<sup>63</sup>  
480

481 In order to ensure data accuracy, prescribers should be able to review their  
482 prescribing history and provide corrections to it, if necessary.  
483

484 iii. Integration and Data Sharing –  
485 In order to minimize any workflow disruption, states should integrate their  
486 PDMP system with electronic health records and pharmacy systems. Ideally,  
487 this integration will provide near-instant and seamless access to critical  
488 prescription history information to both prescribers and pharmacists.  
489

490 States should engage in interstate PDMP data sharing.  
491

492 b. Group 2: Other Characteristics Needed for an Effective PDMP

493 i. Unsolicited reports –

494 In an effort to notify prescribers of a patient’s prescribing information, as  
495 well as the prescriber’s own prescribing history, PDMP systems should  
496 provide unsolicited reports. Examples of information in such reports may  
497 include multiple provider episodes, combinations of commonly misused  
498 drugs, or exceeding a designated threshold for an average daily dose of an  
499 opioid in morphine milligram equivalents.  
500

501 To protect patients, prescribers should generate user-led unsolicited reports  
502 to send to other prescribers treating the same patient. These user-led  
503 unsolicited reports are sent at the discretion of the prescriber and serve as a  
504 judgment that the patient may be receiving a potentially harmful controlled  
505 substance or has experienced a situation, such as an overdose, that may  
506 increase the patient’s future risk of overdose or abuse.  
507

508 When possible, these reports should be sent electronically and should not  
509 contain identifying patient information, but rather alert and direct the  
510 prescriber to query the PDMP to view the information.  
511

512 ii. Educational initiatives –

513 A state medical board may choose to encourage or require prescribers to  
514 complete content-specific continuing medical education related to  
515 prescribing practices including, but not limited to, PDMP utilization.  
516

517 iii. Enhanced user interface –

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<sup>63</sup> The PEW Charitable Trusts, *Prescription Drug Monitoring Programs: Evidence-Based Practices to Optimize Prescriber Use*, December 2016. [www.pewtrusts.org/en/research-and-analysis/reports/2016/12/prescription-drug-monitoring-programs](http://www.pewtrusts.org/en/research-and-analysis/reports/2016/12/prescription-drug-monitoring-programs).

518 PDMP system tools to increase usability for prescribers should be  
519 considered. These components, as part of a PDMP’s interface, may include,  
520 but are not limited to, a summary of morphine milligram equivalent (MME)  
521 for each opioid prescription and a daily MME dose level, as well as any  
522 other “red” flags or alerts for a specific patient.  
523

524 iv. Data Security/Patient Privacy –

525 States should grant PDMP data access to local, state, and federal law  
526 enforcement only when there is an issuance of warrant/judicial finding of  
527 probable cause.  
528

529 States should grant PDMP data access to state medical boards when a  
530 licensee is under investigation by the board for inappropriate prescribing.  
531

532 In order to protect the privacy of patient information and to ensure proper  
533 patient treatment, Medicare, Medicaid, state health insurance programs  
534 and/or health care payment benefit providers and insurers should not have  
535 access to a patient’s PDMP record unless a subpoena has been issued in  
536 accordance with existing subpoena powers.  
537

538 v. Proper funding –

539 To meet the demands of updating and maintaining a PDMP, states should  
540 implement a sustainable funding mechanism, whether through state funding  
541 or federal grant programs.  
542

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**REPORT OF THE BOARD OF DIRECTORS****Subject: Report of the FSMB Workgroup on Physician Wellness and Burnout****Referred to: Reference Committee B**

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The Federation of State Medical Boards (FSMB) Workgroup on Physician Wellness and Burnout, chaired by Dr. Arthur S. Hengerer, M.D., has been tasked with examining the issues of physician wellness and burnout from a regulatory perspective, identifying key patient safety issues, and determining ways in which member boards can be supported.

The Workgroup's charge includes identifying resources and strategies to address physician burnout. In accomplishing its charge, the Workgroup focused on: 1) educating state medical boards and physicians through the creation of a compendium of research and resources on identifying, managing and preventing physician burnout; 2) raising awareness about the prevalence of burnout among physicians and other health care professionals and thereby reducing stigma associated with seeking help for burnout symptoms; 3) evaluating current research on the impact of physician burnout on patient care; and 4) convening stakeholder organizations and experts to discuss physician wellness and recommend best practices for identifying, managing and preventing physician burnout throughout the career continuum.

Over the course of two years, the Workgroup examined the issue of physician burnout from a broad perspective, reviewing existing research, resources, and strategies for addressing it. The Workgroup has drafted a report that includes recommendations, most of which pertain to the licensing and license renewal processes of state medical boards, as well as suggestions for external organizations that aim to address physician burnout. Workgroup members include Mohammed A. Arsiwala, MD; Amy Feitelson, MD; Doris C. Gundersen, MD; Kathleen Haley, JD; Brian J. Miller, MD; Roger M. Oskvig, MD; Michael R. Privitera Jr., MD; Jean L. Rexford; Dana C. Shaffer, DO; Scott A. Steingard, DO; and Barbara E. Walker, DO.

A draft of the report was distributed to FSMB member boards in December 2017, as well as to several external organizations and individuals with a nexus to physician wellness and burnout. Comments received were generally positive and the Workgroup has revised its Report to address them, where appropriate. The FSMB Board of Directors considered the draft *Report of the FSMB Workgroup on Physician Wellness and Burnout* at its meeting on February 7, 2018 in Washington D.C. and discussed clarifications to the document.

**ITEM FOR ACTION:****The Board of Directors recommends that:**

**The House of Delegates ADOPT the recommendations contained in the *Report of the FSMB Workgroup on Physician Wellness and Burnout*, and the remainder of the Report be filed. 65**

# **Attachment 1**

1 **FSMB Workgroup on Physician Wellness and Burnout**

2  
3 **Draft Report and Recommendations**

4  
5  
6 **Executive Summary:**

7  
8 The Federation of State Medical Boards (FSMB) Workgroup on Physician Wellness  
9 and Burnout was convened in April of 2016 by FSMB Chair Arthur S. Hengerer, M.D.  
10 to identify resources and strategies to address physician burnout.

11  
12 While the Workgroup examined the issue of physician burnout from a broad  
13 perspective, reviewing as many facets of this complex issue as possible, including  
14 existing research, resources, and strategies for addressing it, the recommendations  
15 for state medical and osteopathic boards (hereinafter referred to collectively as  
16 “state medical boards”) found in this report focus first and foremost on the licensing  
17 process. The Workgroup also saw fit to include commentary and recommendations  
18 on several other aspects of physician wellness and burnout, though some of these  
19 areas may not be under the direct purview of the FSMB or its member boards. The  
20 FSMB recognizes the importance of collaboration for effectively supporting  
21 physicians and protecting patients in the face of circumstances that lead to burnout,  
22 which is ultimately a patient safety issue. A shared accountability model that  
23 includes responsibilities to be carried out by providers from all the health  
24 professions, including physicians and physician assistants, and with organizations  
25 from across the health care community is therefore recommended as the most  
26 promising course of action to address this important issue.

27  
28 Recommendations for state medical boards related to the licensing process include  
29 considering whether it is necessary to include probing questions about a physician  
30 applicant’s mental health, addiction, or substance use on applications for medical  
31 licensure or their renewal, and whether the information these questions are  
32 designed to elicit, ostensibly in the interests of patient safety, may be better  
33 obtained through means less likely to discourage treatment-seeking among  
34 physician applicants.

35  
36 Where member boards strongly feel that questions addressing the mental health of  
37 physician applicants must be included on medical licensing applications, several  
38 recommendations are included in this report for the appropriate phrasing of such  
39 questions, including focusing only on current impairment, which may be more  
40 meaningful in the context of a physician’s ability to provide safe care to patients in  
41 the immediate future.

42  
43 State medical boards are also encouraged to approach physician wellness and  
44 burnout from a non-punitive perspective, avoiding public disclosure of any  
45 information about a physician’s diagnosis during licensing processes and offering  
46 “safe haven” non-reporting options (mentioned later in this report) to physicians

47 who are under treatment and in good standing with a recognized physician health  
48 program (PHP) or other appropriate care provider.

49  
50 It is also recommended that boards take advantage of all opportunities available to  
51 them to discuss physician wellness, communicate regularly with licensees about  
52 relevant board policies and available resources, and make meaningful contributions  
53 to the ongoing national dialogue about burnout in order to advance a positive  
54 cultural change that reduces the stigma among and about physicians seeking  
55 treatment for mental, behavioral, physical or other medical needs of their own.

56  
57 The Workgroup's recommendations to external organizations and stakeholders  
58 focus on increasing the awareness and availability of information and resources for  
59 addressing physician burnout and improving wellness. The value of noting and  
60 listing the availability of accessible, private, confidential counselling resources is a  
61 particular point of emphasis in this report, as is dedicating efforts to ensuring that  
62 any new regulation, technology, or initiative is implemented with due consideration  
63 to any potential for negative impact on physician wellness.

64  
65 This report, which follows two years of careful study, evaluation and discussion by  
66 Workgroup members, FSMB staff, and various stakeholders, is intended to support  
67 initial steps by the medical regulatory community to begin to address the issues  
68 associated with promotion of physician wellness and mitigation of burnout, to the  
69 extent that is possible. The information and recommendations contained herein are  
70 based on principles of fairness and transparency, and grounded in the primacy of  
71 patient safety. They emphasize a responsibility among state medical boards to work  
72 to ensure physician wellness as a component of their statutory right and duty to  
73 protect patients.

74  
75

## 76 **Background and Charge:**

77  
78 In 2014, the Ethics and Professionalism Committee of the Federation of State  
79 Medical Boards (FSMB) engaged in several discussions about the risks to patient  
80 safety that may result from disruptive physician behavior. As these discussions  
81 proceeded, it became apparent from a review of the literature and discussions with  
82 state medical boards that a link exists between many instances of disruptive  
83 behavior and symptoms of professional burnout experienced by so-called  
84 "disruptive physicians." The Committee, chaired by Dr. Janelle A. Rhyne, M.D., MACP,  
85 determined that further research into physician health, self-care, and burnout  
86 should be conducted to identify resources that may be of value for state medical  
87 boards and physicians alike, and to outline possible roles for the FSMB and its  
88 partners to better promote patient safety and quality health care.

89  
90 Given the complexity of the issue and the many factors contributing to physician  
91 burnout, in 2016, Dr. Arthur S. Hengerer, MD, (while serving as Chair of the FSMB),  
92 established the FSMB Workgroup on Physician Wellness and Burnout to study the

93 issue further. The Workgroup was specifically charged with identifying resources  
94 and strategies to address physician burnout. To accomplish its charge, the  
95 Workgroup reported that it would engage in a multi-part work program that would  
96 likely involve: 1) educating state medical boards and physicians through the  
97 creation of a compendium of research and resources on identifying, managing and  
98 preventing physician burnout; 2) raising awareness about the prevalence of  
99 burnout among physicians and other health care professionals, helping reduce the  
100 stigma sometimes associated with physicians seeking help for burnout symptoms;  
101 3) evaluating current research on the impact of physician burnout on patient care;  
102 and 4) convening stakeholder organizations and experts to discuss physician  
103 wellness and to recommend best practices for promoting physician wellness and  
104 helping physicians identify, manage and prevent burnout throughout their career  
105 continuum (i.e. from medical school through residency training and throughout  
106 their years of licensed, unsupervised practice.)

107  
108 The purpose of this report is to summarize the steps taken by the Workgroup in  
109 fulfilment of their charge, to share information gathered as part of this process, and  
110 to provide a series of recommendations for state medical boards and others to  
111 consider for addressing burnout and its symptoms. It should be noted that the  
112 Workgroup's charge does not include tasks related to defining the phenomenon of  
113 burnout or performing further analysis into the concept itself, as it was felt there is a  
114 significant amount of valuable research that has already been done in these areas  
115 and is ongoing. Much of this research, including some that is inchoate, was reviewed  
116 by the Workgroup in fulfilment of the third component of its charge. This body of  
117 research is referenced herein and informs many of the recommendations contained  
118 in this report. While burnout is a phenomenon that may impact physicians at all  
119 stages of their career, it should be noted that the recommendations specific to state  
120 medical boards in this report focus primarily on the licensing process. The  
121 Workgroup feels it is also important, however, to share information in this report  
122 related to issues beyond the licensing process. Such additional information and  
123 guidance is provided for the benefit of relevant partner organizations and  
124 stakeholders responsible for undergraduate, graduate and continuing medical  
125 education; medical school, residency training and health facility accreditation;  
126 governance, information technology, health insurance, and other activities and  
127 functions that support the provision of health care to the nation's citizens.

128  
129 In developing the content and recommendations of this report, the Workgroup  
130 understands and endorses the importance of the "quadruple aim," which added a  
131 call for improvements in the quality of work lives of physicians and other health  
132 care providers<sup>1</sup> to the existing three aims of improving the health of populations,  
133 enhancing the patient experience of care, and reducing the per capita cost of health

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<sup>1</sup> Bodenheimer T, Sinsky C (2014), From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider. *Ann Fam Med*, 12 (6): 573-576.

134 care.<sup>2</sup> As argued by proponents of the fourth aim, improved population health  
135 cannot be achieved without ensuring the health and well-being of health care  
136 providers.

137  
138 Several definitions have been applied to the phenomenon of physician burnout and,  
139 for the purposes of this report, it is considered a psychological response that may be  
140 experienced by doctors exposed to chronic situational stressors in the health care  
141 practice environment. This is characterized by overwhelming exhaustion, feelings of  
142 cynicism and detachment from work, and a sense of ineffectiveness and lack of  
143 accomplishment.<sup>3</sup> While burnout's manifestations and consequences vary widely,  
144 they could result in significant harm to patients.

145  
146 It has been widely reported for more than a decade that nearly 100,000 preventable  
147 medical errors occur in the United States each year.<sup>4</sup> More recent findings suggest  
148 that between 210,000 and 400,000 deaths each year are associated with  
149 preventable harm.<sup>5</sup> Many of these errors may be attributed to physician burnout  
150 and its drivers, such as excessive caseloads, negative workplace culture, poor work-  
151 life balance, or perceived lack of autonomy in one's work.<sup>6</sup> Burnout affects a  
152 significant proportion of the U.S. physician workforce. A 2012 study conducted by  
153 Shanafelt and colleagues showed that 45.5% of surveyed physicians demonstrated  
154 at least one symptom of burnout.<sup>7</sup> When this study was repeated three years later  
155 with a different sample, the authors demonstrated that burnout and work-life  
156 dissatisfaction had increased by 9% over the three year period.<sup>8</sup> In addition to  
157 obvious risks to patient safety, an alarming and extreme result of physician burnout  
158 has been the disproportionate (relative to the general population) levels of suicide

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<sup>2</sup> Berwick DM, Nolan TW, Whittington J. (2008). The Triple Aim: care, health, and cost. *Health Aff* (Millwood), 27(3):759–69.

<sup>3</sup> Maslach, C., Jackson, S.E. (1981). The Measurement of Experienced Burnout. *Journal of Occupational Behavior*, 2(2):99-113. See also, Maslach C, Jackson SE, Leiter MP. (1996). *Maslach Burnout Inventory Manual*. 3<sup>rd</sup>ed. and Maslach C, et al. (2001). Job Burnout. *Annu Rev Psychol*, 52:397–422.

<sup>4</sup> Kohn LT, Corrigan J, Donaldson MS. (2000). *To Err Is Human: Building a Safer Health System*. Washington, DC: National Academies Press (US).

<sup>5</sup> James JT. (2013). A New, Evidence-based Estimate of Patient Harms Associated with Hospital Care. *Journal of Patient Safety*, 9(3):122-128.

<sup>6</sup> Shanafelt TD, Noseworthy JH. (2016). Executive leadership and physician well-being: Nine organizational strategies to promote engagement and reduce burnout. *Mayo Clin Proc*, 92:129-146.

<sup>7</sup> Shanafelt TD, et al. (2012). Burnout and satisfaction with work-life balance among US physicians relative to the general US population. *Archives of Internal Medicine*, 172(18):1377-1385.

<sup>8</sup> Shanafelt TD, Hasan O, Dyrbye L, et al. (2015). Changes in burnout and satisfaction with work-life balance in physicians and the general US working population between 2011 and 2014. *Mayo Clin Proc*, 90:1600-1613.

159 in recent years by physicians, medical residents and even medical students.<sup>9,10</sup> One  
160 is hard-pressed to find a phenomenon that negatively affects a broader array of  
161 stakeholders in health care than burnout. It impacts providers from all health  
162 professions. State medical boards' duty to protect the public, in this regard, also  
163 includes a responsibility to ensure the wellness of its licensees.  
164

165

### 166 **Features and Consequences of Burnout:**

167

168 Physicians experiencing burnout, according to the medical literature, exhibit a wide  
169 array of signs, symptoms and related conditions, including fatigue, loss of empathy,  
170 detachment, depression, and suicidal ideation. The three principal components of  
171 burnout are widely described in the medical literature as emotional exhaustion,  
172 depersonalization, and diminished feelings of personal accomplishment.<sup>11</sup> Many of  
173 these symptoms are also said to be linked to low levels of career satisfaction.  
174

175

176 Career satisfaction may be diminished by even a single influencing factor.  
177 Unreasonable increases in workload, for example, may quickly lead to  
178 dissatisfaction with one's career. Loss of job satisfaction has been noted as both a  
179 primary contributor to burnout as well as a contributor to its further progression.<sup>12</sup>  
180 Burnout has specifically been found to be the single greatest predictor of surgeons'  
181 satisfaction with career and choice of specialty.<sup>13</sup> It may also be a significant  
182 contributor to increased rates of suicidal ideation among both physicians<sup>14</sup> and  
183 medical students.<sup>15</sup>

183

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<sup>9</sup> Rubin R. (2014). Recent Suicides Highlight Need to Address Depression in Medical Students and Residents. *JAMA*, 312(17):1725-1727.

<sup>10</sup> Gold KJ, Sen A, Schwenk TL. (2013). Details on suicide among US physicians: data from the National Violent Death Reporting System. *Gen Hosp Psych*, 35:45-49.

<sup>11</sup> Maslach C, Schaufeli WB, Leiter MP. (2001). Job burnout. *Annual Review of Psychology*, 52:397-422.

<sup>12</sup> Mirvis DM, Graney MJ, Kilpatrick AO. (1999). Burnout among leaders of the Department of Veterans Affairs medical centers: contributing factors as determined by a longitudinal study. *J Health Hum Serv Adm*, 21:390-412, and Mirvis DM, Graney MJ, Kilpatrick AO. (1999). Trends in burnout and related measures of organizational stress among leaders of Department of Veterans Affairs medical centers. *J Healthc Manag*, 44(5):353-365. (Via Chopra SS. (2004). *JAMA*, 291(5):633).

<sup>13</sup> Shanafelt TD, et al. (2009). Burnout and Career Satisfaction among American Surgeons. *Annals of Surgery*, 250(3):463-471.

<sup>14</sup> Shanafelt TD, Balch CM, Dyrbye LN, et al. (2011). Suicidal ideation among American surgeons. *Arch Surg*, 146:54-62.

<sup>15</sup> Schwenk TL, Davis L, Wimsatt LA. (2010). Depression, stigma, and suicidal ideation in medical students. *JAMA*, 304(11): 1181-1190.

184 Physicians experiencing manifestations of burnout are also reported to be more  
185 prone to engage in unprofessional behavior,<sup>16</sup> commit surgical or diagnostic medical  
186 errors,<sup>17,18,19</sup> and lose the trust<sup>20</sup> of their patients, while also decreasing their  
187 satisfaction.<sup>21</sup> At a time when there is compelling evidence of a shortage of qualified  
188 practicing physicians in many parts of the United States, losing additional physicians  
189 to early or unnecessary retirement would have a detrimental impact on patient  
190 access to care across the country. As the American Medical Association's Policy on  
191 Physician Health and Wellness states, "When health or wellness is compromised, so  
192 may be the safety and effectiveness of the medical care provided."<sup>22</sup>

193  
194

### 195 **Factors Contributing to Burnout:**

196

197 While a large proportion of physicians are said to experience burnout and its  
198 correlates, they do not always experience it in the same way or for the same  
199 reasons. Physicians may be predisposed to burnout because of personality traits  
200 that led them to pursue a medical career in the first place, such as perfectionism,  
201 self-denial, and compulsiveness. These are traits that are said to be common among  
202 practicing physicians. Predisposition to burnout may be stronger in instances where  
203 personal factors such as denial of personal vulnerability, tendencies to delay  
204 gratification, or excess feelings of guilt are layered onto these aforementioned  
205 personality traits. While burnout is a distinct phenomenon from mental illness and  
206 substance use disorders, the latter two issues can play a compounding role in a

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<sup>16</sup> Dyrbye LN, Massie FS, Jr., Eacker A, et al. (2010). Relationship between burnout and professional conduct and attitudes among US medical students. *JAMA*, 304: 1173-1180.

<sup>17</sup> Privitera MR, et al. (2015). Physician Burnout and Occupational Stress: An inconvenient truth with unintended consequences. *Journal of Hospital Administration*, 4(1).

<sup>18</sup> Shanafelt TD, Balch CM, Bechamps G, et al. (2010). Burnout and medical errors among American surgeons. *Ann Surg*, 251:995-1000.

<sup>19</sup> West CP, Huschka MM, Novotny PJ, et al. (2006). Association of perceived medical errors with resident distress and empathy: a prospective longitudinal study. *JAMA*, 296(9):1071-1078.

<sup>20</sup> Haas JS, Cook EF, Puopolo AL, Burstin HR, Cleary PD, Brennan TA. (2000). Is the professional satisfaction of general internists associated with patient satisfaction? *J Gen Intern Med*, 15(2):122-128.

<sup>21</sup> Anagnostopolous F, Liolios E, Persefonis G, Slater J, Kefetsios K, Niakas D. (2012). Physician burnout and patient satisfaction with consultation in primary health care settings: evidence of relationships from a one-with-many design. *J Clin Psychol Med Settings*. 19(4):401-410.

<sup>22</sup> *Code of Medical Ethics*, (2016). American Medical Association, Opinion 9.3.1.

207 physician's struggle with burnout, making the identification and effective treatment  
208 of its symptoms or causes even more difficult.<sup>23</sup>

209  
210 It is a common misconception that physicians are more susceptible to suffering from  
211 burnout at later stages in their career, presumably from fatigue and aging. In fact,  
212 research has demonstrated that physicians in the middle of their careers are at the  
213 highest risk for burnout.<sup>24</sup> Education and training also appear to be critical peak  
214 times for physicians, physicians-in-training or medical students to suffer from  
215 burnout.<sup>25,26</sup>

216  
217 The environment in which physicians work, including their choice of specialty, also  
218 plays a significant role in contributing to burnout. Shanafelt and colleagues have  
219 shown substantial differences in burnout rates by specialty, although changes in the  
220 highest and lowest rates were noted between 2011<sup>27</sup> and 2014.<sup>28</sup> The control, or  
221 lack thereof, that physicians have over their work environment plays a significant  
222 role in predisposition to burnout. This may explain why emergency medicine is  
223 frequently found at or near the top of the list of medical and surgical specialties with  
224 the highest proportion of physicians experiencing burnout. Emergency physicians  
225 often work in environments that are high-demand and low-control.<sup>29</sup> While finding  
226 meaning in one's work has long been claimed to be the antidote to burnout,<sup>30</sup> it may  
227 be difficult to find such meaning absent an adequate degree of control over one's  
228 work environment.

229  
230 The movement towards maximal standardization of processes, often labeled a  
231 phenomenon of "deprofessionalization," is also claimed to be a contributor to  
232 burnout among physicians. There is worry among some professionals, in medicine  
233 and other health care fields, that an expectation for rigid adherence to guidelines

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<sup>23</sup> Oreskovich M, Kaups K, Balch C, et al. (2011). The prevalence of alcohol use disorders among American surgeons. *Arch Surg*, 147:168-174.

<sup>24</sup> Dyrbye LN, et al. (2013). Physician satisfaction and burnout at different career stages. *Mayo Clinic Proceedings*, 88(12):1358-1367.

<sup>25</sup> Dyrbye LN, Shanafelt TD. (2016). A narrative review on burnout experienced by medical students and residents. *Med Educ*, 50:132-149.

<sup>26</sup> Dyrbye LN, et al. (2014). Burnout among U.S. medical students, residents, and early career physicians relative to the general U.S. population. *Academic Medicine*, 89(3):443-451.

<sup>27</sup> Shanafelt TD, et al. (2012). Burnout and satisfaction with work-life balance among US physicians relative to the general US population. *Archives of Internal Medicine*, 172(18):1377-1385.

<sup>28</sup> Shanafelt TD, Hasan O, Dyrbye L, et al. (2015). Changes in burnout and satisfaction with work-life balance in physicians and the general US working population between 2011 and 2014. *Mayo Clin Proc*, 90:1600-1613.

<sup>29</sup> [https://www.medpagetoday.com/emergencymedicine/emergencymedicine/5491](https://www.medpagetoday.com/emergencymedicine/emergencymedicine/54916)

[6](#)

<sup>30</sup> Sotile W. (2002). *The Resilient Physician*.

234 will replace what were formerly considered the more elegant, artistic and satisfying  
235 aspects of medical practice.<sup>31</sup> These movements need not be perceived as threats to  
236 physician autonomy or to the exercise of professional judgment. Rather, embracing  
237 evidence-based medicine, focusing on the value of care that is provided, and  
238 celebrating increasingly positive outcomes can contribute to great improvements in  
239 patient and population health. Professional judgment will continue to play an  
240 important role in realizing these improvements.

241  
242 Frustrations have also been voiced in relation to the move in health care delivery  
243 away from paper-based records to electronic health records (EHRs). Many  
244 physicians have expressed dissatisfaction with the intrusiveness and complexity of  
245 EHR use and the limits this sometimes places on the ways in which they are able and  
246 capable of effectively documenting treatment decisions and provision of care.<sup>32</sup>  
247 These frustrations exist in addition to those related to the often complex, redundant,  
248 or non-intuitive methods of data entry and other elements of medical record  
249 keeping associated with EHRs,<sup>33,34,35</sup> as well as the fact that most systems are not yet  
250 fully interoperable. However, complaints made about particular aspects of an  
251 evolving or disruptive technology should not be interpreted as calls to abandon the  
252 important gains in patient safety, professional communication, and even efficiency  
253 that have been brought about by the introduction and implementation of EHR  
254 systems. Rather, they should be interpreted as important user feedback that may  
255 contribute to ongoing improvement of such technology.

256  
257 The constantly changing and evolving nature of medicine, as well as the challenges  
258 faced by the American health care system itself, also appear to be affecting the way  
259 many physicians feel within their professional roles. A recent study reported that  
260 65% of physicians who were surveyed predicted an ongoing deterioration in the  
261 quality of health care that they deliver, which in turn has been attributed, in part, to  
262 the erosion of physician autonomy.<sup>36</sup> When evolving requirements are layered onto

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<sup>31</sup> Aasland OG. (2015). Healthy Doctors – Sick Medicine. *Professions and Professionalism*, 5(1).

<sup>32</sup> Friedberg MW, et al. (2013). Factors Affecting Physician Professional Satisfaction and Their Implications for Patient Care, Health Systems, and Health Policy. RAND Corporation, [https://www.rand.org/pubs/research\\_reports/RR439.html](https://www.rand.org/pubs/research_reports/RR439.html).

<sup>33</sup> Arndt BG, et al. (2017). Tethered to the EHR: Primary Care Physician Workload Assessment Using EHR Event Log Data and Time-Motion Observations. *Ann Fam Med*, 15(5):419-426.

<sup>34</sup> Levinson J, Price BH, Saini V. (2017). Death By A Thousand Clicks: Leading Boston Doctors Decry Electronic Medical Records. *Common Health*, <http://www.wbur.org/commonhealth/2017/05/12/boston-electronic-medical-records>.

<sup>35</sup> Sinsky C, et al. (2016) Allocation of Physician Time in Ambulatory Practice: A Time and Motion Study in 4 Specialties. *Ann Intern Med*. 165:753-760.

<sup>36</sup> Emanuel EJ, Pearson SD. (2012). Physician autonomy and health care reform. *Journal of the American Medical Association*, 307(4), 367-368.

263 new expectations with regard to technology, quality reporting, increased clinical  
264 volume, and numerous other initiatives required by payers, employers, and even  
265 state medical boards, it may not be surprising that physicians are experiencing  
266 burnout at alarming rates. While many of the initiatives that place additional  
267 burdens on physicians are grounded in strong rationales related to patient safety  
268 and quality care, the burnout resulting from their combined effect may actually  
269 inhibit the success of the initiatives themselves.<sup>37</sup> This should certainly bring pause  
270 to those charged with implementing initiatives and requirements to carefully  
271 evaluate their effectiveness, unintended consequences, and potential burden, but  
272 also to communicate their goals and perceived value. The reaction of the profession  
273 to the ongoing changes that are occurring may also indicate particular attitudes  
274 within the culture of medicine that would benefit from further discussion, as would  
275 support to integrate positive change into practice.

276  
277 Burnout is not always related to stressors arising in a physician's work environment  
278 or to a physician's character traits. Family issues, personal and professional  
279 relationships, financial pressures, insufficient work-life balance, or other external  
280 stressors may also contribute to burnout. Efforts aimed at the identification,  
281 treatment, or prevention of burnout must, therefore, approach the issue from a  
282 broad enough perspective to take all of these factors into account.

283  
284

#### 285 **Challenges and Barriers to Addressing Burnout:**

286

287 While there has been a promising rise in the number of peer-reviewed research  
288 publications addressing the topic of physician burnout, in the academic medical  
289 literature, popular media and so-called gray literature (e.g., white papers, position  
290 statements, organizational reports), there seems to be a perceived lack of resources  
291 available to identify and address the issue. This perception may be misguided,  
292 however, since several academic institutions, health systems, medical specialty  
293 societies, independent physicians, physician health programs, and state medical  
294 boards make many useful, high-quality resources available (See Appendix A.). While  
295 more resources would be beneficial to physicians, and ultimately their patients,  
296 their development should be complemented with efforts aimed at highlighting best  
297 practices. Research is also needed to identify how sources of burnout might differ  
298 for male and female physicians in order that resources may be appropriately  
299 tailored. A more coordinated effort to raise awareness not only about the issue of  
300 physician burnout but also about resources for ameliorating related circumstances  
301 may also serve to reduce stigma and facilitate identification and treatment. It may  
302 also help improve systems issues that impact burnout by improving communication,  
303 team building, and collaboration within and among health care professions. Broader

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<sup>37</sup> Dyrbye LN, Shanafelt TD. (2011). Physician Burnout: A Potential Threat to Successful Health Care Reform. *JAMA* 305(19):2009-2010.

304 awareness may also better equip physicians in their capacity as leaders to improve  
305 circumstances for those with whom they work.<sup>38</sup>  
306  
307 Many physicians are reluctant to seek help for burnout or any of its many  
308 underlying causes for fear that they will be perceived as weak or unfit to practice  
309 medicine by their colleagues or employers, or because they assume that seeking  
310 such care may have a detrimental effect on their ability to renew or retain their state  
311 medical license, arguably the most important credential a physician receives during  
312 their professional career.<sup>39,40,41,42,43</sup> This stigma may be felt as early as medical  
313 school,<sup>44</sup> a particularly dangerous cultural feature in a population where symptoms  
314 of anxiety and depression have been found to be more prevalent than in the general  
315 population.<sup>45</sup> In a study by Dyrbye and colleagues, it was found that only a third of  
316 the medical students experiencing features of burnout sought help and that stigma  
317 was seen as a barrier for those who chose not to seek help.<sup>46</sup> The same reluctance is  
318 seen with respect to help-seeking for other types of stigmatized suffering such as  
319 depression, substance use disorders, or suicidal ideation.<sup>47</sup> Without adequate  
320 modeling of appropriate self-care behaviors among faculty mentors, progress at  
321 stigma reduction will likely be slow. Further, while there are laudable examples of  
322 programs at academic medical centers across the country which responsibly offer

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<sup>38</sup> Shanafelt TD, et al. (2015). Impact of Organizational Leadership on Physician Burnout and Satisfaction, *Mayo Clinic Proceedings*, 90(4):432-440.

<sup>39</sup> Chew-Graham CA, et al. (2003). 'I wouldn't want it on my CV or their records': medical students' experiences of help-seeking for mental health problems. *Medical Education*, 37(10):873-880.

<sup>40</sup> Federation of State Medical Boards. (2011). Policy on Physician Impairment.

<sup>41</sup> Guille C, et al. (2010). Utilization and Barriers to Mental Health Services Among Depressed Medical Interns: A Prospective Multisite Study, *Journal of Graduate Medical Education*, 2(2):210-214.

<sup>42</sup> Gold K, et al. (2016). "I would never want to have a mental health diagnosis on my record": A survey of female physicians on mental health diagnosis, treatment, and reporting. *General Hospital Psychiatry*, 43:51-57.

<sup>43</sup> Dyrbye LN, et al. (2017). Medical Licensure Questions and Physician Reluctance to Seek Care for Mental Health Conditions. *Mayo Clin Proc*, 92(10):1486-1493.

<sup>44</sup> Schwenk TL, et al. (2010). Depression, Stigma, and Suicidal Ideation in Medical Students. *JAMA*, 304(11):1181-1190.

<sup>45</sup> Rotenstein LS, Ramos MA, Torre M, et al. (2016). Prevalence of depression, depressive symptoms, and suicidal ideation among medical students, a systematic review and meta-analysis. *JAMA*, 316(21):2214-2236.

<sup>46</sup> Dyrbye LN, et al. (2015). The Impact of Stigma and Personal Experiences on the Help-Seeking Behaviors of Medical Students with Burnout. *Academic Medicine*, 90(7):961-969.

<sup>47</sup> Dyrbye LN, et al. (2017). Medical Licensure Questions and Physician Reluctance to Seek Care for Mental Health Conditions. *Mayo Clin Proc*, 92(10):1486-1493.

323 accessible, complementary, private, and confidential counselling to medical  
324 students,<sup>48</sup> these programs are by no means widely available.

325

326 Privacy and confidentiality of a physician's health and treatment history is  
327 important to allow those in need of help to come forward without fear of  
328 punishment, disciplinary action, embarrassment or professional isolation. The use  
329 of confidential services whenever possible in lieu of regulatory awareness is  
330 preferred in order to mitigate fear of negative impacts on licensure, employment, or  
331 collegial relationships. When confidential services are not utilized, it is less likely  
332 licensees will receive early intervention and appropriate treatment, thereby  
333 foregoing opportunities for early detection of potentially impairing illness or  
334 recovery.

335

336 Funding for important programs and initiatives such as those identified above is  
337 often difficult to obtain. However, there is a growing body of research that identifies  
338 the cost savings for hospitals and employers associated with providing them,  
339 particularly when costs associated with medical errors and lower quality of care  
340 attributed to burnout are mitigated, as are high turnover rates, absenteeism, and  
341 loss of productivity.<sup>49</sup>

342

343 Another challenge to identifying and addressing burnout is the fact that the  
344 associated stigma may reduce the degree to which the phenomenon itself is  
345 discussed. This impacts not only a physician's own willingness to discuss or seek  
346 help for burnout, but also the willingness of fellow physicians to address or report  
347 instances of impairment among their colleagues, especially that which unduly risks  
348 the safety of patients. While the duty to report impairment or incompetence and the  
349 duty to encourage help-seeking may seem to conflict, in that a fear of being reported  
350 could cause a physician to conceal problems and avoid help, the duty to report is  
351 actually based on principles of patient safety and ethics. The duty to report also  
352 aims to assist physicians in seeking the help they need in order to continue  
353 practicing safely.

354

355 In addition to the cultural stigma associated with admitting experiences of burnout,  
356 recent research has shed light on the potential impact of licensure and license  
357 renewal processes of state medical boards that may discourage treatment-seeking

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<sup>48</sup> Examples include the HEAR Program at UC San Diego (available to everyone at the UCSD Health System, not only medical students), the Henderson Student Counseling Center at Nova Southeastern University, the Wellness Resources offered at Oregon Health and Science University, and the Medical Student Counseling and Wellness Center at the Herbert Wertheim College of Medicine, Florida International University.

<sup>49</sup> Shanafelt T, Goh G, Sinsky C. (2017). The Business Case for Investing in Physician Well-Being. *JAMA Intern Med.* 177(12):1826-1832.

358 among physicians.<sup>50,51</sup> State medical boards may inadvertently discriminate unfairly  
359 against physicians suffering from mental illness or substance use disorders, or  
360 against those who choose to take a leave of absence from practice to prevent or  
361 recover from burnout. The very presence of application questions for medical  
362 licensure or licensure renewal may stigmatize those suffering from mental and  
363 behavioral illnesses for which physicians might otherwise seek care. In fact,  
364 questions about substance abuse and mental illness on state medical licensure  
365 renewal applications have nearly doubled between 1996 and 2006.<sup>52</sup> While  
366 information about a physician's health status (both mental and physical) may be  
367 essential to a state medical board's solemn duty to protect the public, the FSMB has  
368 previously noted that a history of mental illness or substance use does not reliably  
369 predict future risk to the public.<sup>53</sup> It is also very important to recognize that court  
370 interpretations of the Americans with Disabilities Act (ADA) have suggested that  
371 state medical boards should focus on current functional impairment rather than a  
372 history of diagnoses or treatment of such illness.<sup>54</sup>

373  
374 In carrying out their duty to protect the public and ensure that only individuals who  
375 are fully qualified to practice medicine are granted licenses, state medical boards  
376 usually, and for good reasons, insist that they must have sufficient information with  
377 which to make medical licensure decisions. During the licensure granting process,  
378 state boards also work diligently to ensure that candidates for licensure (or  
379 renewal) provide a thorough assessment of their fitness to practice, balanced by  
380 protecting their rights as contained in ADA legislation. Fear among prospective and  
381 current licensees about potential limitations placed on their ability to practice  
382 medicine independently, however, or of their previous diagnoses or treatments  
383 somehow being made public despite HIPAA and other federal privacy and  
384 confidentiality laws, may cause some physicians to misrepresent personal  
385 information that is requested or not respond accurately at all to licensing  
386 application questions.<sup>55</sup> In such instances, paradoxically, the efforts of state medical  
387 boards to get comprehensive information may not yield the accurate information

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<sup>50</sup> Gold K, et al. (2016). "I would never want to have a mental health diagnosis on my record": A survey of female physicians on mental health diagnosis, treatment, and reporting. *General Hospital Psychiatry*, 43:51-57.

<sup>51</sup> Dyrbye LN, et al. (2017). Medical Licensure Questions and Physician Reluctance to Seek Care for Mental Health Conditions. *Mayo Clin Proc*, 92(10):1486-1493.

<sup>52</sup> Polfliet SJ. (2008). A National Analysis of Medical Licensure Applications. *J Am Acad Psychiatry Law*, 36(3): 372.

<sup>53</sup> Federation of State Medical Boards. (2006). Federation of State Medical Boards: Americans With Disabilities Act of 1990. License Application Questions: A Handbook for Medical Boards.

<sup>54</sup> Polfliet SJ. (2008). A National Analysis of Medical Licensure Applications. *J Am Acad Psychiatry Law*, 36(3):373.

<sup>55</sup> Gold K, et al. (2016). "I would never want to have a mental health diagnosis on my record": A survey of female physicians on mental health diagnosis, treatment, and reporting. *General Hospital Psychiatry*, 43:51-57.

388 they seek about a physician’s practice risks to patients. They may also discourage  
389 treatment-seeking among physicians, thereby increasing the degree of risk to  
390 patients presented by physicians experiencing conditions that remain undiagnosed  
391 or untreated.

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394 **Recommendations:**

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396 The majority of the recommendations that follow are designed for state medical  
397 boards to consider and pertain mainly to the inclusion and phrasing of questions on  
398 state medical licensing applications. Appropriately addressing the issue of physician  
399 burnout provides a unique opportunity for state medical boards to declare, directly  
400 or indirectly, that it is not only normal but anticipated and acceptable for a physician  
401 to feel overwhelmed from time to time and to seek help when appropriate. This is  
402 also an important opportunity for state medical boards to highlight and promote the  
403 benefits of physician health, both mental and physical, to help reduce stigma, to  
404 clarify related regulatory and reporting issues, promote patient safety and assure  
405 the delivery of quality health care. Physicians should feel safe about reporting  
406 burnout and be able to take appropriate measures to address it without fear of  
407 having their licensure status placed in jeopardy.

408

409 Safeguarding physician wellness and mitigating damage caused by burnout cannot  
410 be accomplished through isolated actions and initiatives by individual organizations  
411 alone. Coordinated efforts and ongoing collaboration will be essential not only for  
412 addressing the many systemic issues that contribute to burnout but also for  
413 ensuring that appropriate tools, resources, and programs are continuously in place  
414 and readily available to help physicians avoid and address burnout. As such, the  
415 FSMB also offers suggestions and recommendations to its partner organizations,  
416 many of which have been instrumental in furthering the FSMB’s current  
417 understanding of burnout, its related features, and the role of the regulatory  
418 community in addressing and safeguarding physician health.

419

420 Ultimately, the Workgroup and the FSMB believe that a shared accountability model  
421 that includes several related responsibilities among regulatory, educational,  
422 systemic, organizational, and administrative stakeholders provides a promising way  
423 forward. The specific recommendations outlined below begin to address what such  
424 responsibilities should entail.

425

426 The FSMB recognizes its responsibility to help address physician burnout, not only  
427 through following its own recommendations and promoting the resources provided  
428 in this report, but also by continuing its collaborative efforts with partner  
429 organizations from across the wider health care community.

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434 **For State Medical Boards:**

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1. The FSMB recommends that state medical boards review their medical licensure (and renewal) applications and **evaluate whether it is necessary to include probing questions about a physician applicant’s mental health, addiction, or substance use**, and whether the information these questions are designed to elicit in the interests of patient safety may be obtained through means that are less likely to discourage treatment-seeking among physician applicants. For example, some boards subscribe to notification services such as the National Practitioner Data Bank’s “Continuous Query” service or other data services that provide information about arrests or convictions, including for driving under the influence, within their states which can serve as a proxy finding for physician impairment. The FSMB also recommends in its *Essentials of a State Medical and Osteopathic Practice Act* that boards require applicants to satisfactorily pass a criminal background check as a condition of licensure.<sup>56</sup>
2. Where state medical boards strongly feel that questions addressing the mental health of physician applicants must be included on medical licensing applications, they should **carefully review their applications to ensure that appropriate differentiation is made between the illness with which a physician has been diagnosed and the impairments that may result**. Application questions must focus only on current impairment and not on illness, diagnosis, or previous treatment in order to be compliant with the Americans with Disabilities Act (ADA).
3. The ADA requires licensure application questions to focus on the presence or absence of current impairments that are meaningful in the context of the physician’s practice, competence, and ability to provide safe medical treatment to patients. **Applications must not seek information about impairment that may have occurred in the distant past and state medical boards should limit the time window for such historical questions to two years or less, though a focus on the presence or absence of current impairment is preferred.**

**Questions that address the mental health of the applicant should be posed in the same manner as questions about physical health**, as there is no distinction between impairment that might result from physical and mental illness that would be meaningful in the context of the provision of safe treatment to patients.

Where boards wish to retain questions about the health of applicants on licensing applications, **the FSMB recommends that they use the language**

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<sup>56</sup> Federation of State Medical Boards. (2015). *Essentials of a State Medical and Osteopathic Practice Act*.

477 **recommended by the American Psychiatric Association:**  
478 ***“Are you currently suffering from any condition that impairs your***  
479 ***judgment or that would otherwise adversely affect your ability to***  
480 ***practice medicine in a competent, ethical and professional manner?***  
481 **(Yes/No)”<sup>57,58</sup>**

- 482  
483 4. **The FSMB recommends that state medical boards consider offering the**  
484 **option of “safe haven non-reporting” to applicants for licensure who**  
485 **are receiving appropriate treatment for mental health or addiction.**  
486 While it is up to boards to determine what constitutes appropriate  
487 treatment, the FSMB recommends that physicians who are monitored by,  
488 and in good standing with, the recommendations of a state or territorial  
489 Physician Health Program (PHP) be permitted to apply for medical licensure  
490 or license renewal without having to disclose their diagnosis or treatment to  
491 the board. The option of safe haven non-reporting should only be offered  
492 when treatment received is commensurate with the illness being treated  
493 and has a reasonable chance of avoiding any resultant impairment.  
494  
495 5. **State medical boards should work with their state legislatures to**  
496 **ensure that the personal health information of licensees related to an**  
497 **illness or diagnosis is not publicly disclosed as part of a board’s**  
498 **processes.** Information disclosed must relate only to impairment of  
499 professional abilities, medical malpractice, and professional misconduct.<sup>59</sup>  
500  
501 6. **State medical boards should emphasize the importance of physician**  
502 **health, self-care, and treatment-seeking for all health conditions by**  
503 **including a statement to this effect on medical licensing applications,**  
504 **state board websites, and other official board communications.** Where  
505 appropriate, options for treatment and other resources should be made  
506 available, such as information about a state Physician Health Program (PHP),  
507 services offered through a county, state, or national medical society, and any  
508 other relevant programs. These means of communicating the importance of  
509 physician health and self-care are aimed at helping physicians with relevant  
510 information and resources but could also help raise awareness among  
511 patients of the importance of physician wellness and the threat of burnout to  
512 their doctors and their own care.

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<sup>57</sup> American Psychiatric Association. (2015). Position statement on inquiries about diagnosis and treatment of mental disorders in connection with professional credentialing and licensing.

<sup>58</sup> The American Psychiatric Association (APA) passed an Action Paper in November 2017, resolving to query state medical boards and notify them about their compliance with APA policy and the ADA.

<sup>59</sup> Center C, Davis M, Detre T, et al. (2003). Confronting depression and suicide in physicians: a consensus statement. *JAMA*, 289(23):3161–3166.

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7. **State medical boards should clarify through communications, in print and online, that an investigation is not the same as a disciplinary undertaking.** Achieving an understanding of this distinction among licensees may help begin to dispel the stigma associated with reporting burnout and remove a barrier to physicians seeking help in times of need.
8. **State medical boards are encouraged to maintain or establish relationships with a PHP in their state and to support the use of data from these programs in a board’s decision-making.**
9. **State medical boards should examine the policies and procedures currently in place for working with physicians who have been identified as impaired in a context that is meaningful for the provision of safe care to patients to ensure that these are fair, reasonable, and fit for the purpose of protecting patients. All such processes should be clearly explained and publicly available.**
10. **State medical boards should be aware of potential burdens placed on licensees by new or redundant regulatory requirements.** They should seek ways of facilitating compliance with existing requirements to support licensees and ensure that they are able to spend time with patients and in those areas of medicine which they find most meaningful. “Reducing the cumulative burden of rules and regulations may improve professional satisfaction and enhance physicians' ability to focus on patient care.”<sup>60</sup>

Upon implementing some or all of the above changes to state medical board policy or processes that are meant to reduce the stigma associated with mental health issues and encourage treatment-seeking, the board should communicate these, and their rationale, to current and prospective licensees, as well as patients and the public. State medical boards should also raise the issue of physician burnout more often, emphasizing the importance of physician wellness, help-seeking, and the availability of accessible, confidential, and private counselling programs for physicians and all health professionals.

**For External Stakeholders and Partner Organizations:**

*Professional Medical Organizations and Societies:*

11. Professional medical societies at local, state, and national levels have a key role to play in encouraging physicians to seek treatment, both preventive

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<sup>60</sup> Friedberg MW, et al. (2013). Factors Affecting Physician Professional Satisfaction and Their Implications for Patient Care, Health Systems, and Health Policy. RAND Corporation, [https://www.rand.org/pubs/research\\_reports/RR439.html](https://www.rand.org/pubs/research_reports/RR439.html).

555 and curative, for the physical and mental health issues they face, as well as  
556 for features of burnout. The FSMB recognizes the many exemplary programs  
557 and initiatives of professional medical societies and encourages their  
558 continued advocacy for physician wellness and the availability of support  
559 and treatment services.

560

561 12. The FSMB recommends a sustained focus in the medical profession on the  
562 importance of self-care with an aim to reduce the stigma attached with  
563 seeking treatment for health issues, particularly ones related to mental  
564 health.

565

566 13. The FSMB recommends that attempts be made to expand the availability of  
567 accessible, private, and confidential counseling for physicians through  
568 medical societies, such as those provided by organizations like the Lane  
569 County Medical Society (Oregon), which has a program with several features  
570 identified as best practices for physician wellness by the Workgroup.  
571 Counseling via telehealth could also enhance access and provide greater  
572 assurance of privacy to those seeking care.

573

574 14. Given the prevalence of burnout, all physicians need to be educated about  
575 the resources currently available regarding burnout, including those  
576 referenced in Appendix A, for self-awareness, and for identification and  
577 referral of peer professionals who may have burnout. Medical societies are  
578 encouraged to partner with other organizations identified in this report to  
579 improve awareness of resources and their dissemination.

580

581 15. The FSMB recommends that professional medical societies and  
582 organizations representing physicians, such as the American Medical  
583 Association, the American Osteopathic Association, and the Council of  
584 Medical Specialty Societies work with state medical boards to raise  
585 awareness among the public of the importance of physician wellness not  
586 only because of its inherent value to physicians themselves but also as a  
587 significant contributor to patient safety.

588

589

590 Centers for Medicaid and Medicare Services:

591

592 16. The FSMB recommends careful analysis of any new requirements placed on  
593 physicians to determine their potential impact on physician wellness. Any  
594 new requirements that could serve as a driver of burnout in physicians must  
595 be supported by evidence and accompanied by a strong rationale that is  
596 based in improving patient care to justify any new burdens imposed on  
597 physicians.

598

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600

601 State Government, Health Departments, and Legislatures:

602

603 17. As state government, health departments, and legislatures make decisions  
604 that can impact physicians, the FSMB recommends that they weigh the  
605 potential value of proposed new regulations against potential risks to the  
606 health of physicians and other clinicians.

607

608

609 Vendors of Electronic Health Records (EHR) systems and standard setting  
610 organizations:

611

612 18. As a promising advancement in the provision and documentation of care,  
613 but also a key driver of frustration with medical practice, EHRs need to be  
614 improved in a way that takes the user experience into greater consideration  
615 than it does currently. This experience may be improved through facilitating  
616 greater ease of data entry into the system, as well as ease of access to data  
617 from the system. Vendors are encouraged to include end-user physicians on  
618 their builder teams to optimize input about operability and interoperability.

619

620 19. Efforts to reduce redundant or duplicative entry should be required by  
621 standard setting organizations, such as the Office of the National  
622 Coordinator for Health IT (ONC), and reflected in the EHR systems  
623 ultimately designed by vendors.

624

625 20. EHR vendors are encouraged to focus future improvements on facilitating  
626 and improving the provision of patient care. The primary purposes of an  
627 EHR relate to documentation of care received by a patient, retrieval of  
628 patient care related information and data, and patient communication.

629

630

631 Medical Schools and Residency Programs:

632

633 21. The FSMB encourages the Accreditation Council for Graduate Medical  
634 Education, the Association of American Medical Colleges, the American  
635 Association of Colleges of Osteopathic Medicine, the American Medical  
636 Association, the American Osteopathic Association and the institutions they  
637 represent, to continue their laudable efforts at improving the culture of  
638 medicine and facilitating open conversations about illness and wellness in  
639 order to promote positive change.

640

641 22. The FSMB recommends continued efforts to encourage medical students and  
642 residents to value self-care and understand the positive impacts that  
643 physician wellness can have on patient care.

644

645 23. The FSMB recommends that medical schools, residency programs, and their  
646 accrediting bodies consider ways of amplifying the medical student and

647 resident voice on systemically induced pressures and support trainees by  
648 providing means for raising issues related to medical student and resident  
649 health and well-being anonymously.

650

651

652 Hospitals/Employers:

653

654 24. The FSMB recommends that hospitals revise, where necessary and  
655 appropriate, their questions asked as part of their credentialing process  
656 according to the recommendations made above for the medical licensing  
657 community to ensure that these are not discouraging physicians or other  
658 health professionals from seeking needed treatment.

659

660 25. The FSMB recommends that hospitals and health systems assess physician  
661 health at regular intervals using a validated instrument and act upon the  
662 results. Employers should keep results of these assessments internal to the  
663 organization or health system in order to promote workplace change, while  
664 avoiding threatening or punitive cultures.

665

666 26. Hospitals, as well as the American Hospital Association and related  
667 organizations, are encouraged to officially adopt the “Quadruple Aim” to  
668 demonstrate the importance they place in the health and wellness of the  
669 physicians and all other health professionals they employ and recognize the  
670 impact of provider health on safe patient care.

671

672 27. Hospitals should ensure that their policies and procedures are adopted with  
673 consideration given to the impact they have on the health of the hospital  
674 workforce. Decisions impacting hospital the health of hospital and health  
675 system employees should be made with adequate input from individuals  
676 representing the impacted sectors of that workforce.

677

678 28. While acknowledging the need for hospitals to acknowledge all staff in their  
679 programmatic development, employers are encouraged to make resources  
680 and programs available to physicians, including time and physical space for  
681 making connections with colleagues and pursuing personal goals that add  
682 meaning to physicians’ work lives. Resources and programs should not  
683 always be developed and implemented in a “one size fits all” manner, but  
684 should incorporate consideration of the different stressors placed on male  
685 and female physicians, within and outside of the workplace, and be tailored  
686 appropriately. Resources related to EHR implementation and use should  
687 also be made available by employers, including training to optimize use and  
688 support for order-entry such as scribes or other technological solutions  
689 aimed at restoring time available to physicians.

690

691 29. Hospitals should ensure that mandatory reports related to physician  
692 competence and discipline are made available to state medical boards and  
693 other relevant authorities.  
694

695

696

Insurers:

697

698 30. The FSMB recommends that insurance carriers revise, where necessary and  
699 appropriate, their questions on applications for professional liability  
700 insurance according to the recommendations made above for the medical  
701 licensing community to ensure that these are not discouraging physicians or  
702 other health professionals from seeking needed treatment.  
703

704

705 31. In evaluating the quality of care provided by physicians, insurers should  
706 look beyond cost-saving measures and use metrics related to physician  
707 health and incentivize practice patterns that contribute to physician  
708 wellness.  
709

710

711

Accrediting Organizations:

712

713 32. In its ongoing development of standards for the accreditation of  
714 undergraduate medical education programs, graduate medical education  
715 training programs, hospitals and healthcare facilities,  
716 the FSMB encourages those organizations charged with the accreditation of  
717 institutions and educational programs to include standards related to required  
718 resources and policies aimed at protecting medical student, medical resident  
719 and attending physician health.  
720

721

722

Physicians:

723

724 33. Physician wellness is a complex issue, made up of system-wide and  
725 individual components. However, physicians have a responsibility to attend  
726 to their own health, well-being, and abilities in order to provide care of the  
727 highest standard.<sup>61</sup> This involves a responsibility to continually self-assess  
728 for indicators of burnout, discuss and support the identification of health  
729 issues with peers, and seek help or treatment when necessary. Physicians  
730 are encouraged to make use of services of state Physician Health Programs,  
731 which, where available, can be accessed confidentially in instances where  
732 patient harm has not occurred.

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<sup>61</sup> General Assembly of World Medical Association at Geneva Switzerland. (1948).  
*Declaration of Geneva*, as amended by the WMA General Assembly, October 2017.

733 34. Physicians are encouraged to inform themselves about their ethical duty,  
734 oftentimes codified in state statutes, to report issues related to  
735 incompetence and unsafe care delivered by their peers. They are also  
736 encouraged to engage in open dialogue with peers about the importance of  
737 self-care, treatment-seeking, and the threats to themselves and their  
738 patients presented by burnout.  
739

740 35. Physicians are also encouraged to seek an appropriate balance between time  
741 spent on practice and related work and activities external to work,  
742 particularly ones with restorative potential.  
743

744

#### 745 **Conclusion**

746

747 The duty of state medical boards to protect the public includes a responsibility to  
748 ensure physician wellness and to work to minimize the impact of policies and  
749 procedures that impact negatively on the wellness of licensees, both prospective  
750 and current. The rationale for this duty is based on the link between physician  
751 burnout and its attendant risks to patient safety, the fact that some regulatory  
752 processes employed by state medical boards can have negative impacts on the  
753 health and wellness of physicians themselves, and the potential for regulatory  
754 change to support physician wellness and help prevent further instances of burnout.  
755

756 The information and recommendations in this Report of the FSMB's Workgroup on  
757 Physician Wellness and Burnout are meant to support initial steps in the medical  
758 regulatory community and to contribute to ongoing conversation about patient  
759 safety and physician health.  
760

761 **FSMB WORKGROUP ON PHYSICIAN WELLNESS AND BURNOUT**

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809 President and CEO, FSMB

**STAFF SUPPORT:**

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Director, Continuing Professional Development,  
FSMB

810 **APPENDIX A: SAMPLE RESOURCE LIST**

811

812 The following list is offered as a sample of resources available to support and  
813 facilitate the understanding, diagnosis, treatment, and prevention of symptoms of  
814 burnout or to maintain and improve physician wellness. The FSMB has not  
815 conducted an in-depth evaluation of individual resources, and inclusion herein does  
816 not indicate, nor is it to be interpreted as, an endorsement or guarantee of quality.  
817 Further, while some resources listed below are available free of charge, others are  
818 only accessible through purchase.

819

820 Federation of State Medical Boards, [Policy on Physician Impairment](#), 2011.

821

822 Federation of State Medical Boards: Americans With Disabilities Act of 1990. License  
823 Application Questions: A Handbook for Medical Boards. Dallas, TX: Federation of  
824 State Medical Boards of the United States, Inc., 2006.

825

826 The standard tool used to evaluate rates of burnout is the [Maslach Burnout](#)  
827 [Inventory](#), developed in the 1980s by [Christina Maslach, PhD](#), a psychologist at the  
828 University of California Berkeley.

829

830 The [HappyMD.com](#) – in particular, the burnout prevention matrix, 117 ways to  
831 prevent burnout

832

833 Accreditation Council for Graduate Medical Education – [Physician Wellbeing](#)  
834 [Resources](#)

835

836 American Academy of Family Physicians - [Physician Burnout Resources](#) Page:

837

838 American College of Emergency Physicians (ACEP) – ACEP [Wellness Resource](#) page

839

840 American College of Physicians – [Resources on Physician Well-Being and](#)  
841 [Professional Satisfaction](#)

842

843 American Medical Association [Steps Forward](#) website:

844

845 American Osteopathic Association – [AOA Physician Wellness Strategy](#)

846

847 Association of American Medical Colleges – [Wellbeing in Academic Medicine](#)

848

849 [Federation of State Physician Health Programs](#)

850

851 [Mayo Physician Well-being Program](#):

852

853 [National Academy of Medicine Action Collaborative on Clinician Well-Being and](#)  
854 [Resilience](#)

855

856 [Remembering the Heart of Medicine](#)  
857  
858 [Stress Management and Resiliency Training](#) (SMART) program  
859  
860 [SuperSmartHealth](#)  
861  
862 The [Studer Group](#)  
863  
864 [The Well-Being Index](#) (Mayo Clinic)  
865

DRAFT

## REPORT OF THE BOARD OF DIRECTORS

**Subject:**                    **Guidelines for the Structure and Function of a State Medical and Osteopathic Board**

**Referred to:**            **Reference Committee A**

Since 1988, the FSMB’s *Guide to the Essentials of a Modern Medical Practice Act* and *Elements of a State Medical and Osteopathic Board* have functioned as companion documents to provide state medical boards a useful blueprint for their structure and functions as stated in their medical practice act. These policies have served as a highly effective stimulus to medical boards and state legislatures for periodic review and revision of their statutes. The policies are revised every three years. The Advisory Council of Board Executives is charged with updating the policies to ensure currency and recommending the revisions to the Board of Directors. The 2017 Advisory Council includes Kimberly Kirchmeyer, Micah T. Matthews, MPA, Maegan Martin, JD, Frank B. Meyers, JD, Kathleen Selzler Lippert, JD, Kevin D. Bohnenblust, JD, Mark E. Bowden, MPA, Kathleen Haley, JD, and Ian Marquand.

The Advisory Council of Board Executives met on August 17, 2017 in Washington, DC, to revise the *Elements* and *Essentials* for consideration by the FSMB House of Delegates at its Annual Meeting in April 2018. At this meeting the Council considered a full agenda in meeting its charge to conduct a review and revision of the *Essentials* and *Elements of a State Medical and Osteopathic Act*. As part of its meeting, the Council conducted a thorough review of the licensure by endorsement provisions in accordance with Resolution 17-3, Review of Model Guidelines for State Medical Boards Granting Licensure by Endorsement and Assessment of the Standards of ACGME International.

As a result of in person discussions and in response to feedback from member state boards, the Council agreed to condense the *Elements* and *Essentials* into one document, *Guidelines for the Structure and Function of a State Medical and Osteopathic Board (Attachment 1)*. The Council determined that a singular guidance document on state medical board structure would reduce redundancies inherent in the original two documents and allow for a more dynamic and user-friendly resource for member state boards. The Council recommended that existing FSMB policy regarding licensure by endorsement not be amended to include reference to ACGME-International.

*Guidelines for the Structure and Function of a State Medical and Osteopathic Board* incorporates the contents of prior *Elements* and *Essentials*, containing the principles of state medical board responsibility, duty, empowerment, and accountability that the initial documents outlined, as well as detailing the essential components for the structure and function of a state medical board. This

guidance document reflects not only relevant characteristics of effective modern medical boards, but also a number of innovative concepts not yet widely implemented. Though presented for consideration as an integrated whole, the guidelines offer significant approaches to a variety of issues that concern many boards, including: funding and budgeting, confidentiality, board authority, personnel and staffing, administration, emergency powers, training of board members, immunity and indemnity, standards of evidence, and the public's right to know.

Recognizing the differences among jurisdictions, this document is designed with the flexibility to accommodate as many of those differences as possible, while maintaining the integrity of the overall concept. Some sections empower boards to adopt alternatives of their choice, provided they are in accord with other state statutes, while other sections are phrased loosely to allow boards necessary discretionary authority. These guidelines may thus be seen not as one proposal but as various proposals.

A draft of the *Guidelines for the Structure and Function of a State Medical and Osteopathic Board* was distributed to FSMB member boards and other key stakeholder organizations in December 2017 with comments due January 31, 2018. There were no suggestions for modification received. No comments were received. The FSMB Board of Directors considered the draft *Guidelines for the Structure and Function of a State Medical and Osteopathic Board* at its meeting on February 7, 2018 in Washington D.C. and discussed clarifications to the document.

#### **ITEM FOR ACTION:**

**The Board of Directors recommends that:**

**The House of Delegates ADOPT *Guidelines for the Structure and Function of a State Medical and Osteopathic Board*, superseding *Guide to the Essentials of a Modern Medical Practice Act (HOD 2015)* and *Elements of a State Medical and Osteopathic Board (HOD 2015)*.**

# **Attachment 1**

# Guidelines for the Structure and Function of a State Medical and Osteopathic Board

## 1 Introduction

2 As early as 1914, the Federation of State Medical Boards (FSMB), which now represents 70 state and  
3 territorial medical and osteopathic licensing and disciplinary boards (hereafter referred to as “state  
4 medical board(s)” or “Board(s)”), recognized the need for a guidance document supporting U.S. states  
5 and territories in their development, and updating as needed, of their medical practice acts, and the  
6 corresponding structures and functions of their medical boards.

7 Following extensive consultations with members and staff of state medical boards, and a review of  
8 emerging best practices, the FSMB first issued *A Guide to the Essentials of a Modern Medical Practice*  
9 *Act* in 1956. The stated purposes of this guidance document were:

- 10 1. To serve as a guide to those states that may adopt new medical practice acts or may amend  
11 existing laws; and
- 12 2. To encourage the development and use of consistent standards, language, definitions, and tools  
13 by boards responsible for physician and physician assistant regulation.

14 Over the years, dynamic changes in medical education, in the practice of medicine, and in the diverse  
15 responsibilities that face medical boards have necessitated frequent revision of a state or territory’s  
16 medical practice act. *The Essentials* has since undergone numerous revisions to respond to these  
17 changes and assist member boards to be consistent with best practices in the interests of public  
18 protection and patient safety.

19 In 1988, the Division of Medicine of the Bureau of Health Professions, Health Resources and Services  
20 Administration (HRSA), in the U.S. Department of Health and Human Services, requested proposals for  
21 the development of a parallel document on a state medical board’s structure and function. The FSMB  
22 proposed a new guidance document in response, called the *Elements of a State Medical and*  
23 *Osteopathic Board*. The Bureau of Health Profession and HRSA accepted the FSMB’s proposal, and the  
24 document was soon developed and made available for consideration by the public, state medical  
25 boards, medical organizations, and other relevant groups.

26 The primary focus of the *Elements* document was to develop a blueprint of the structure and function of  
27 a modern state medical board. It detailed the powers, duties, and protections that are basic to a state  
28 medical board’s structure and function. In that context, it reflected the understanding, concepts,  
29 opinions, knowledge and experience of the individuals comprising the work panel, which included  
30 members, attorneys and staff of state medical boards. The *Elements* presented a blueprint that was  
31 consistent with the principles expressed in the *Essentials*, and was offered as a stimulus for discussion of  
32 several issues vital to improving the regulation of the medical profession in the United States.

33 The *Elements* and *Essentials* have, since 1988, functioned as companion documents to provide state

34 medical boards a useful blueprint for their structure and functions as stated in their medical practice act.  
35 Revised by the FSMB's Advisory Council of Board Executives every three years to remain current, the  
36 model policies have served as a highly effective stimulus to medical boards and state legislatures for  
37 periodic review and revision of their statutes.

38 In 2017, the Advisory Council met to revise the *Elements* and *Essentials* for consideration by the FSMB  
39 House of Delegates at its Annual Meeting in April 2018. At this meeting and in response to feedback  
40 from member state boards, the Advisory Council considered and agreed to condense the two model  
41 policies into one document. The Advisory Council determined that a singular guidance document on  
42 state medical board structure would reduce redundancies inherent in the original two documents and  
43 allow for a more dynamic and user-friendly resource for member state boards.

44 The guidance document that follows incorporates the contents of prior *Elements* and *Essentials*  
45 documents, containing the principles of state medical board responsibility, duty, empowerment, and  
46 accountability that the initial documents outlined, as well as detailing the essential components for the  
47 structure and function of a state medical board.

48 This guidance document reflects not only relevant characteristics of effective modern medical boards,  
49 but also a number of innovative concepts not yet widely implemented. The result is a document worthy  
50 of consideration for adaptation to the requirements of any state or territorial jurisdiction. Although it  
51 could hardly be expected that any one jurisdiction would accept every component of this model, it  
52 should lead every jurisdiction to assess its present board structure and function. Does the status quo  
53 provide maximum potential for protection of the public interest? Though presented for consideration as  
54 an integrated whole, the guidelines offer significant approaches to a variety of issues that concern many  
55 boards, including: funding and budgeting, confidentiality, board authority, personnel and staffing,  
56 administration, emergency powers, training of board members, immunity and indemnity, standards of  
57 evidence, and the public's right to know.

58 Recognizing the differences among jurisdictions, this document is designed with the flexibility to  
59 accommodate as many of those differences as possible, while maintaining the integrity of the overall  
60 concept. Some sections empower boards to adopt alternatives of their choice, provided they are in  
61 accord with other state statutes, while other sections are phrased loosely to allow boards necessary  
62 discretionary authority. These guidelines may thus be seen not as one proposal but as various proposals.  
63 Each is applicable in one form or another to a diversity of settings, and all are aimed at increasing or  
64 refining the ability of state medical boards to better protect the health, safety and welfare of the public.

65 The Federation urges member boards to consider including any recommendations contained herein in  
66 their respective medical practice acts, rules, or their own guidance documents.

67 The following guidelines apply equally to boards that govern physicians who have acquired the M.D. or  
68 D.O. degree, and the terms used herein should be interpreted throughout with this understanding.

## Table of Contents

69	Introduction .....	1
70	Section I. Definitions .....	6
71	Section II. The Medical Practice Act.....	8
72	Statement of purpose .....	8
73	Exemptions .....	9
74	Unlawful Practice of Medicine .....	10
75	Section III. State Medical Board Duty, Responsibility, and Power.....	10
76	Section IV. State Medical Board Membership .....	14
77	Composition and Size.....	14
78	Qualifications .....	15
79	Terms .....	15
80	Requirements.....	16
81	Appointment.....	16
82	Removal .....	16
83	Compensation/Reimbursement .....	17
84	Section V. State Medical Board Structure.....	17
85	Officers.....	17
86	Committees.....	17
87	Funding .....	18
88	Revenues.....	18
89	Budget.....	18
90	Setting Fees and Charges .....	18
91	Fiscal Year .....	18
92	Section VI. Meetings of the Board and Committee of the Board .....	18
93	Location.....	18
94	Frequency, Duration .....	19
95	Special Meetings, Conferences .....	19
96	Notice.....	19
97	Quorum.....	19

98	Conflict of Interest .....	19
99	Minutes .....	19
100	Open Meetings.....	20
101	Confidentiality.....	20
102	Section VII. Administration of the State Medical Board .....	21
103	Offices .....	21
104	Administration .....	21
105	Staff, Special Personnel.....	21
106	Special Support Personnel .....	22
107	Section VIII. Immunity, Indemnity, Protected Communication.....	22
108	Immunity.....	22
109	Qualified Immunity and Indemnity.....	22
110	Protected Communication.....	24
111	Section IX. Reports of the Board .....	24
112	Annual Report .....	24
113	Public Record, Action Reports .....	25
114	Section X. Examinations.....	26
115	Section XI. Requirements for Full Licensure .....	26
116	Graduates of Foreign Medical Schools .....	28
117	Section XII. Licensure by Endorsement, Expedited Licensure by Endorsement, and Temporary and Special	
118	Licensure .....	29
119	Endorsement for Licensed Applicants .....	29
120	Expedited Licensure by Endorsement.....	30
121	Temporary Licensure .....	31
122	Special Licensure.....	31
123	Section XIII. Limited Licensure for Physicians in Postgraduate Training.....	31
124	Postgraduate Training Program Reporting Requirements .....	32
125	Section XIV: Periodic Renewal .....	32
126	Section XV. Disciplinary Process .....	34
127	Range of Actions .....	34
128	Grounds for Action.....	35
129	Enforcement and Disciplinary Action Procedures .....	38

130	Section XVI: Compulsory Reporting and Investigation .....	40
131	Section XVII. Impaired Physicians .....	41
132	Section XVIII: Dyscompetent and Incompetent Licensees.....	43
133	Section XIX: Physician Assistants .....	44
134	Administration .....	44
135	Licensing.....	44
136	Rules and Regulations.....	45
137	Disciplinary Actions.....	45
138	Duties and Scope of Practice .....	45
139	Responsibility of Supervising Physician .....	45
140	Renewal.....	45

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## 142 Section I. Definitions

143 The following terms have the following meanings:

144 “Assessment Program” means a formal system to examine or evaluate a physician’s competence within  
145 the scope of the physician’s practice.

146 “Competence” means possessing the requisite abilities and qualities (cognitive, non-cognitive, and  
147 communicative) to perform effectively within the scope of the physician’s practice while adhering to  
148 professional ethical standards.

149 “Dyscompetence” means failing to maintain acceptable standards in one or more areas of professional  
150 physician practice. (HOD 1999)

151 “Impairment” means a physician’s inability to practice medicine with reasonable skill and safety due to:

- 152 1. Mental, psychological, or psychiatric illness, disease, or deficit;
- 153 2. Physical illness or condition, including, but not limited to, those illnesses or conditions that  
154 would adversely affect cognitive, motor, or perceptive skills; or
- 155 3. Habitual, excessive, or illegal use or abuse of drugs defined by law as controlled substances,  
156 illegal drugs, alcohol, or of other impairing substances.

157 “Incompetence” means lacking the requisite abilities and qualities (cognitive, non-cognitive, and  
158 communicative) to perform effectively in the scope of the physician’s practice.

159 “License” means any license, certificate, or other practice authorization granted by the Board pursuant  
160 to the medical practice act, or any other applicable statute.

161 “Licensee” means the holder of any license, certificate, or other practice authorization granted by the  
162 Board.

163 “Licensed physician” means a physician licensed to practice medicine in the jurisdiction.

164 “Medical Practice Act” means the statute that determines the structure and function of a state medical  
165 or osteopathic board. Section II below addresses categories that the medical practice act does not  
166 typically apply to.

167 “Physician assistant” means a skilled person who by training, scholarly achievements, submission of  
168 acceptable letters of recommendations, and satisfaction of other requirements of the Board has been  
169 licensed for the provision of patient services under the supervision and direction of a licensed physician  
170 who is responsible for the performance of that person.

171 “Physician Assistant Council” means a council appointed by the Board or other means that reviews  
172 matters relating to physician assistants, reports its findings to the Board, and makes recommendations  
173 for action.

174 “Practice of medicine” is consistent with the following:

- 175 1. Advertising, holding out to the public, or representing in any manner that one is authorized to  
176 practice medicine in the jurisdiction;
- 177 2. Offering or undertaking to prescribe, order, give, or administer any drug or medicine for the use  
178 of any other person;
- 179 3. Offering or undertaking to prevent or to diagnose, correct, and/or treat in any manner or by any  
180 means, methods, or devices any disease, illness, pain, wound, fracture, infirmity, defect, or  
181 abnormal physical or mental condition of any person, including the management of pregnancy  
182 and parturition;
- 183 4. Offering or undertaking to perform any surgical operation upon any person;
- 184 5. Rendering a written or otherwise documented medical opinion concerning the diagnosis or  
185 treatment of a patient or the actual rendering of treatment to a patient within a state by a  
186 physician located outside the state as a result of transmission of individual patient data by  
187 electronic or other means from within a state to such physician or the physician's agent;
- 188 6. Rendering a determination of medical necessity or a decision affecting the diagnosis and/or  
189 treatment of a patient; and
- 190 7. Using the designation Doctor, Doctor of Medicine, Doctor of Osteopathic Medicine/Doctor of  
191 Osteopathy, Physician, Surgeon, Physician and Surgeon, Dr., M.D., D.O., or any combination  
192 thereof in the conduct of any occupation or profession pertaining to the prevention, diagnosis,  
193 or treatment of human disease or condition unless such a designation additionally contains the  
194 description of another branch of the healing arts for which one holds a valid license in the  
195 jurisdiction where the patient is located.

196 The definition of the practice of medicine may also include several exceptions, which exempt certain  
197 activities from the categorization of the practice of medicine.

198 The practice of medicine is determined to occur where the patient is located in order that the full  
199 resources of the state are available for the protection of that patient.

200 "Remediation" means the process whereby deficiencies in physician performance identified through an  
201 examination or assessment program are corrected, resulting in an acceptable state of physician  
202 competence.

203 "Supervising physician" means a licensed physician in good standing in the same jurisdiction as the  
204 physician assistant who the Board approved to supervise the services of a physician assistant, and who  
205 has in writing formally accepted the responsibility for such supervision.

206 "Telemedicine" means the practice of medicine using electronic communications, information  
207 technology, or other means between a licensee in one location, and a patient in another location, with  
208 or without an intervening healthcare provider. Generally, telemedicine is not an audio-only, telephone  
209 conversation, e-mail/instant messaging conversation, or fax. It typically involves the application of  
210 secure videoconferencing or store and forward technology to provide or support healthcare delivery by  
211 replicating the interaction of a traditional, encounter in person between a provider and a patient. (HOD  
212 2014)

## 213 Section II. The Medical Practice Act

214 The structure and function of each of the 70 medical regulatory boards (allopathic, osteopathic and  
215 composite) within the United States and its territories are determined by a unique state statute (or  
216 group of statutes), usually referred to as a medical practice act. The differences among these statutes  
217 are related to the general administrative structure of each jurisdiction and to the needs of the public as  
218 they are perceived by each responsible legislative body.

219 The following section is not intended to encourage movement toward total uniformity among these  
220 statutes. Given the diversity of administrative structures and the variations in perceived needs, that  
221 would be a futile exercise. The existing differences do have a positive creative value, allowing the  
222 evolution and testing of a range of new approaches in a number of jurisdictions concurrently. Rather, it  
223 is intended to nurture that creativity by encouraging the public, state legislators, medical boards,  
224 medical societies, and others who have an interest in the regulation of the medical profession to  
225 reexamine existing practice acts as they relate to the composition, structure, functions, responsibilities,  
226 powers, and funding of medical boards.

227 The medical practice act should provide for a separate state medical board, acting as a governmental  
228 agency to regulate the practice of medicine, in order to protect the public from unlawful, incompetent,  
229 unqualified, impaired, or unprofessional practitioners of medicine, through licensure, regulation, and  
230 rehabilitation of the medical profession in the state.

231 Generally, the medical practice act should authorize Boards to promulgate rules and regulations to  
232 facilitate the enforcement of the act. Boards should be authorized to adopt and enforce rules and  
233 regulations to carry out the provisions of the medical practice act and to fulfill their duties under the act.  
234 Boards should adopt rules and regulations in accord with administrative procedures established in the  
235 respective jurisdiction.

### 236 Statement of purpose

237 The medical practice act should be introduced by a statement of policy specifying the purpose of the act.  
238 This statement should include language expressing the following concepts:

- 239 • The practice of medicine is a privilege granted by the people acting through their elected  
240 representatives.
- 241 • In the interests of public health, safety, and welfare, and to protect the public from the  
242 unprofessional, improper, incompetent, unlawful, fraudulent, and/or deceptive practice of  
243 medicine, it is necessary for the government to provide laws and regulations to govern the  
244 granting and subsequent use of the privilege to practice medicine.
- 245 • The primary responsibility and obligation of the state medical board is to act in the sovereign  
246 interests of the government by protecting the public through licensing, regulation and education  
247 as directed by the state government.

248 Sample Statement of Purpose:

249 *As a matter of public policy, the practice of medicine is a privilege granted by*  
250 *the people of the State acting through their elected representatives by their*  
251 *adoption of the Medical Practice Act. It is not a natural right of individuals.*  
252 *Therefore, in the interests of public health, safety and welfare, and to protect*  
253 *the public from the unprofessional, improper, incompetent, unlawful,*  
254 *fraudulent, and/or deceptive practice of medicine, it is necessary to provide*  
255 *laws and regulations to govern the granting and subsequent use of the privilege*  
256 *to practice medicine and to ensure, as much as possible, that only qualified and*  
257 *fit persons hold that privilege. The Board's primary responsibility and obligation*  
258 *is to protect the public, and any license, certificate or other practice*  
259 *authorization issued pursuant to this statute shall be a revocable privilege and*  
260 *no holder of such a privilege shall acquire thereby any irrevocable right.*

## 261 Exemptions

262 The medical practice act should not apply to:

- 263 1. Students while engaged in training in a medical school approved or recognized by the state  
264 medical board, unless the board licenses the student;
- 265 2. Those providing service in cases of emergency where no fee or other consideration is  
266 contemplated, charged or received by the physician or anyone on behalf of the physician;
- 267 3. Commissioned medical officers of the armed forces of the United States and medical officers of  
268 the United States Public Health Service or the Veterans Administration of the United States in  
269 the discharge of their official duties and/or within federally controlled facilities, provided that  
270 such persons who hold medical licenses in the jurisdiction should be subject to the provisions of  
271 the act and provided that all such persons should be fully licensed to practice medicine in one or  
272 more jurisdictions of the United States. Further, the military physician should be subject to the  
273 Military Health System Clinical Quality Assurance (CQA) Program 10 U.S.C.A. § 1094; Regulation  
274 DOD 6025.13-R;
- 275 4. Those practicing dentistry, nursing, optometry, psychology, or any other of the healing arts in  
276 accord with and as provided by the laws of the jurisdiction;
- 277 5. Those practicing the tenets of a religion or ministering religious based medical procedures or  
278 ministering to the sick or suffering by mental or spiritual means in accord with such tenets;
- 279 6. Those administering a lawful domestic or family remedy to a member of one's own family;
- 280 7. Those fully licensed to practice medicine in another jurisdiction of the United States who briefly  
281 render emergency medical treatment or briefly provide critical medical service at the specific  
282 lawful direction of a medical institution or federal agency that assumes full responsibility for  
283 that treatment or service and is approved by the state medical board; and
- 284 8. Those fully licensed to practice medicine in another jurisdiction of the United States who is  
285 employed or formally designated as the team physician by an athletic team visiting the  
286 jurisdiction for a specific sporting event, and the physician limits the practice of medicine in the  
287 jurisdiction to medical treatment of the members, coaches, and staff of the sports entity that  
288 employs (or has designated) the physician.

## 289 Unlawful Practice of Medicine

290 The medical practice act should provide a definition of the unlawful practice of medicine and penalties  
291 for such unlawful practice. These provisions of the act should implement or be consistent with the  
292 following:

- 293 1. It should be unlawful for any person, corporation, or association to perform any act constituting  
294 the practice of medicine as defined in the medical practice act without first obtaining a medical  
295 license in accord with that act and the rules and regulations of the Board. Other licensed health  
296 care professionals may provide medical services within the scope of their authorizing license.
- 297 2. The Board should be authorized to issue a cease-and-desist order<sup>1</sup> and/or obtain injunctive relief  
298 against the unlawful practice of medicine by any person, corporation, or association.
- 299 3. It should be a felony for any person, corporation, or association that performs any act  
300 constituting the practice of medicine as defined in the medical practice act, or causing or aiding  
301 and abetting such actions.
- 302 4. A physician located in another state practicing within the state by electronic or other means  
303 without a license (full, special purpose or otherwise) issued by the Board should be deemed  
304 guilty of a felonious offense.

## 305 Section III. State Medical Board Duty, Responsibility, and Power

306 In some states, responsibility for licensing and disciplinary functions is divided between two separate  
307 Boards. In others, Boards are subject to supervision or, in some cases, complete control by larger  
308 administrative or umbrella agencies. In a few states, the Board is simply an advisory body. In most  
309 states, the Board regulates both allopathic and osteopathic physicians; in others, separate boards exist.  
310 And in some states, narrow constitutional restrictions inhibit effective Board funding. Clearly, the  
311 following section proposes a true working board with real and effective power and support, a proposal  
312 some states are much better prepared to implement than others. But it is also a reflection of those  
313 principles the authors consider to be basic to the operation of any accountable medical board,  
314 regardless of the administrative structure of the state, the size or distribution of the physician  
315 population being regulated, the form of legislation required for funding, or the title of the body to which  
316 responsibility and power for regulation have been entrusted. It may be drawn upon by both allopathic  
317 and osteopathic boards, making appropriate adaptations in the area of Board membership. Larger  
318 administrative agencies can use it to better assess their own structures and functions and to explore the  
319 broader roles their medical boards might play in meeting public expectations.

320 It is necessary that Boards have the responsibilities and powers necessary to fulfill the duties conferred  
321 on the Board by the medical practice act. These duties, responsibilities, and powers are to be liberally  
322 construed to protect the health, safety, and welfare of the people of the Board's State. It is the duty of  
323 Boards to determine a physician's initial and continuing qualification and fitness for the practice of  
324 medicine. Boards should be empowered to initiate proceedings against the unprofessional, improper,

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<sup>1</sup> In light of the recent U.S. Supreme Court case, *North Carolina Board of Dental Examiners v. Federal Trade Commission*, it is currently unclear whether the reliance on cease-and-desist orders to regulate the unlicensed practice of medicine by state medical boards is a best practice.

325 incompetent, unlawful, fraudulent, deceptive, or unlicensed practice of medicine, and enforce the  
326 medical practice act and related rules. Boards should discharge these duties and responsibilities in  
327 accord with the medical practice act and other governing laws.

328 In addition to any other duty, responsibility, and power provided to the Board in the medical practice  
329 act, the Board, acting in accord with its medical practice act and the requirements of due process,  
330 should:

- 331 1. Enforce the provisions of the medical practice act;
- 332 2. Develop, adopt and enforce rules and regulations to affect the provisions of medical practice act  
333 and to fulfill the Boards duties there under;
- 334 3. Select and/or administer licensing examination(s);
- 335 4. Employ or contract with one or more organizations or agencies known to provide acceptable  
336 examinations for the preparation, administration, and scoring of required examinations;
- 337 5. Prepare, select, conduct, or direct the conduct of, set passing requirements for, assure security  
338 of, and impose conditions for (e.g., time or attempt limits) successful completion of the licensing  
339 and other required examinations;
- 340 6. Impose conditions, sanctions, deny licensure, levy fines, seek appropriate civil and/or criminal  
341 penalties, or any combination of these, against those who violate or attempt to violate  
342 examination security, those who obtain or attempt to obtain licensure by fraud or deception,  
343 and those who knowingly assist in such activities;
- 344 7. Acquire information about and evaluate medical education and training of applicants;
- 345 8. Determine which professional schools, colleges, universities, training institutions, and  
346 educational programs are acceptable relating to licensure under the medical practice act and  
347 are appropriately preparing physicians for the practice of medicine, and to accept the approval  
348 of such facilities and programs by Board-recognized accrediting bodies in the United States and  
349 Canada;
- 350 9. Develop and use applications and other necessary forms and related procedures it finds  
351 appropriate for purposes of the medical practice act;
- 352 10. Require supporting documentation or other acceptable verifying evidence of any information  
353 provided the Board by an applicant or licensee;
- 354 11. Require information on and evaluate an applicant's or a licensee's fitness, qualification, and  
355 previous professional record and performance from recognized data sources, including, but not  
356 limited to, the Federation of State Medical Boards' Federation Physician Data Center, other  
357 national data repositories, licensing and disciplinary authorities of other jurisdictions,  
358 professional education and training institutions, liability insurers, health care institutions, and  
359 law enforcement agencies;
- 360 12. Issue, condition, or deny initial or endorsement licenses;
- 361 13. Maintain secure and complete records on individual licensees including, but not limited to  
362 license application, verified credentials, disciplinary information, and malpractice history;
- 363 14. Provide the public with a profile of all licensed physicians;
- 364 15. Process and approve or deny applications for license renewal and review of a licensee's

- 365 activities for that time period;
- 366 16. Develop and implement methods to identify physicians who are in violation of the medical  
367 practice act;
- 368 17. Require the self-reporting by applicants or licensees of any information the Board determines  
369 may indicate possible deficiencies in practice, performance, fitness, or qualification.
- 370 18. Require all licensees, healthcare professionals, healthcare facilities, and medical societies and  
371 organizations to report to the Board information that appears to show another licensee is, or  
372 may be, professionally incompetent, guilty of unprofessional conduct, or mentally or physically  
373 unable to engage safely in licensed practice, and to report to the Board and/or to an agency  
374 designated by the Board a licensee's possible dependence on alcohol or other addictive  
375 substances which have the potential to impair. Require licensees, malpractice insurance  
376 companies, attorneys, and healthcare facilities to report any payments on a demand, claim,  
377 settlement, arbitration award or judgment by or on behalf of a licensee;
- 378 19. Develop and implement methods to identify and rehabilitate, if appropriate, physicians with an  
379 alcohol, drug, and/or psychiatric illness;
- 380 20. When deemed appropriate by the Board to do so, require professional competency, physical,  
381 mental or chemical dependency examination, and evaluations of any applicant or licensee,  
382 including withdrawal and laboratory examination of bodily fluids;
- 383 21. Establish a mechanism, which at the Board's discretion, may involve cooperation with and/or  
384 participation by one or more Board-approved professional organizations, for the identification  
385 and monitored treatment of licensees who are dependent on or abuse alcohol or other  
386 addictive substances which have the potential to impair;
- 387 22. Establish a mechanism by which licensees who believe they abuse or may be dependent on or  
388 addicted to alcohol or other addictive substances which have the potential to impair, and who  
389 have not been identified by the Board through other sources of information, will be encouraged  
390 to report themselves voluntarily to the Board and/or, at the Board's discretion, to a professional  
391 organization approved by the Board to seek assistance and monitored treatment;
- 392 23. Receive, review, and investigate complaints and adverse information about licensees, including  
393 *sua sponte* complaints;
- 394 24. Review and investigate reports received from entities having information pertinent to the  
395 professional performance of licensees;
- 396 25. Act to halt the unlicensed or illegal practice of medicine; review, investigate, and take  
397 appropriate action to enjoin reports received concerning the unlicensed practice of medicine;  
398 and seek penalties against those engaged in such practices;
- 399 26. Adjudicate those matters that come before it for judgement under the medical practice act and  
400 issue final decisions on such matters;
- 401 27. Share investigative information at the early stages of a complaint investigation with other  
402 Boards;
- 403 28. Issue cease and desist orders and to obtain court orders and injunctions to halt unlicensed  
404 practice, violation of this statute or the rules of the Board;
- 405 29. Institute actions in its own name and enjoin violators of the medical practice act;
- 406 30. Act on its own motion in disciplinary matters, administer oaths, issue notices, issue subpoenas in

- 407 the name of the state including for patient records, receive testimony, conduct hearings,  
408 institute court proceedings for contempt to compel testimony or obedience to its orders and  
409 subpoenas, take evidentiary depositions, and perform such other acts as are reasonably  
410 necessary under the medical practice act or other laws to carry out its duties;
- 411 31. Issue subpoenas in the course of an investigation, including for *duces tecum* to compel  
412 production of documents or testimony to any party or entity that may possess relevant  
413 information regarding the subject of the investigation;
- 414 32. Institute proceedings in courts of competent jurisdiction to enforce its orders and the provisions  
415 of the medical practice act;
- 416 33. Use preponderance of the evidence as the standard of proof and to issue final decisions;
- 417 34. Present to the proper authorities information it believes indicates an applicant or licensee may  
418 be subject to criminal prosecution;
- 419 35. Discipline licensees found in violation of the medical practice act;
- 420 36. Issue conditioned, restricted, or otherwise circumscribed licenses as it determines necessary;
- 421 37. Take the following actions, in accord with applicable state statutes, alone or in combination,  
422 against those found in violation of the medical practice act:
- 423 a. Revoke, suspend, condition, restrict, and/or otherwise limit the license;
- 424 b. Place the licensee on probation with conditions;
- 425 c. Levy fines and/or assess the costs of proceedings against the licensee;
- 426 d. Censure, reprimand and/or otherwise admonish the licensee;
- 427 e. Require the licensee to provide monetary redress to another party, and/or provide a  
428 period of free public or community service;
- 429 f. Require the licensee to satisfactorily complete an educational, training, and/or  
430 treatment program or programs; and
- 431 g. Require the licensee to successfully complete an examination, examinations, or  
432 evaluations designated by the Board; and
- 433 38. Summarily suspend a license when there is imminent risk of the public health and safety prior to  
434 hearing and final adjudication;
- 435 39. Enforce final disciplinary action against a licensee as deemed necessary to protect public health  
436 and safety;
- 437 40. Report all final disciplinary actions, non-administrative license withdrawals as defined by the  
438 Board, license denials, and voluntary license limitations or surrenders related to physicians, with  
439 any accompanying license limitations or surrenders related to physicians, with any  
440 accompanying Board orders, findings of fact and conclusions of law, to the Federation Physician  
441 Data Center of the Federation of State Medical Boards of the United States and to any other  
442 data repository required by law, and report all such actions, denials and limitations or  
443 surrenders related to other licensees, with the same supporting documentation, to the National  
444 Practitioner Data Bank as required by law;
- 445 41. Develop policies for disciplining or rehabilitating physicians who demonstrate inappropriate  
446 sexual behavior with patients or other professional boundaries violations;
- 447 42. Acknowledge receipt of complaints or other adverse information to persons or entities reporting  
448 to the Board and to the physician, and inform them of the final disposition of the matters

- 449 reported;
- 450 43. Develop and implement methods to identify dyscompetent physicians and physicians who fail to
- 451 meet acceptable standards of care;
- 452 44. Develop or identify and implement methods to assess and improve physician practice;
- 453 45. Develop or identify and implement methods to ensure the ongoing competence of licensees;
- 454 46. Determine and direct the Board's operating, administrative, personnel, and budget policies and
- 455 procedures in accord with applicable state statutes;
- 456 47. Acquire real property or other capital for the administration and operation of the Board;
- 457 48. Set necessary fees and charges to ensure active and effective pursuit of all of its responsibilities,
- 458 legal and otherwise;
- 459 49. Develop and adopt its budget;
- 460 50. Employ, direct, reimburse, evaluate, and dismiss when appropriate the Board's executive
- 461 director, in accord with the Board's state's procedures; Supervision of staff is the purview of the
- 462 executive director.
- 463 51. Develop, recommend, and adopt rules, standards, policies, and guidelines related to
- 464 qualifications of physicians and medical practice;
- 465 52. Engage in a full exchange of information with the licensing and disciplinary boards of other
- 466 states and jurisdictions of the United States and foreign countries;
- 467 53. Direct the preparation and circulation of educational material, policies, and guidelines the Board
- 468 determines is helpful and proper for licensees;
- 469 54. Develop educational programs to facilitate licensee awareness of provisions contained in the
- 470 medical practice act and to facilitate public awareness of the role and function of state medical
- 471 boards;
- 472 55. Delegate to the executive director the Board's authority to discharge its duties as appropriate;
- 473 and
- 474 56. Recommend to the Legislature those changes in, or amendments to, the medical practice act
- 475 that the Board determines would benefit the health, safety, and welfare of the public.

## 476 Section IV. State Medical Board Membership

477 Whatever the professional regulatory structure established by the government of the jurisdiction, the

478 state medical board bears the primary responsibility for licensing and regulating the medical profession

479 for the protection of the public. Every Board should include both physician and public members. All

480 Board members should act to further the interest of the state, and not their personal interests.

### 481 Composition and Size

482 The Board should consist of enough members to appropriately discharge the duties of the Board, at

483 least 25% of whom should be public members. The Board should consider several factors when

484 determining the appropriate size and composition of a Board, including the size of a state's physician

485 population, the composition and functions of Board committees, adequate separation of prosecutorial

486 and judicial powers, and the other work of the Board envisions throughout this document. The Board

487 should be of sufficient size to allow for recusals due to conflicts of interest and other occasional member

488 absences without concentrating final decisions in the hands of too few members or loss of quorum.

## 489 Qualifications

490 The membership of the Board should be drawn from as many different regions of the State, as many  
491 different specialties as possible, and should reflect the licensee population.

492 Members should be citizens of the United States who have attained the age of majority as defined in the  
493 statutes of the State.

494 Sex, race, national or ethnic origin, creed, religion, disability, or age above majority shall not be used as  
495 the sole reason for making an individual eligible or ineligible to serve on the Board.

496 All physician members of the Board should be in active practice<sup>2</sup> (HOD 2012), hold full and unrestricted  
497 medical licenses in the jurisdiction, be persons of recognized professional ability and integrity, and  
498 should have resided or practiced in the jurisdiction long enough to have become familiar with the laws,  
499 policies, and practice in the jurisdiction (e.g., five years).

500 Public members of the Board should reside in the Board's respective jurisdiction and be persons of  
501 recognized ability and integrity; are not licensed physicians, providers of health care, or retired  
502 physicians or health care providers; have no past or current substantial personal or financial interests in  
503 the practice of medicine or with any organization regulated by the Board (except as a patient or care  
504 giver of a patient); and have no immediate familial relationships with individuals involved in the practice  
505 of medicine or any organization regulated by the Board, unless otherwise required by law.

506 Members of the Board should not be registered as a lobbyist representing any health care interest or  
507 association nor be an officer, Board member, or employee of a statewide or national organization  
508 established for advocating the interests of individuals involved in the practice of medicine or any  
509 organization regulated by the Board.

## 510 Terms

511 Members of the Board, whether appointed or elected, should serve staggered terms to ensure  
512 continuity. All appointments and elections should be confirmed through the legislative branch of the  
513 jurisdiction. The length of terms on the Board should be set to permit development of effective skill and  
514 experience by members (e.g., three or four years). However, a limit should be set on consecutive terms  
515 of service (e.g., two or three consecutive terms).

516 The term of Board service shall be three to four years.

517 A person should not serve as a member of the Board for more than three consecutive full terms, but  
518 may be reappointed two years after completion of such service. A person who serves more than two

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<sup>2</sup> FSMB Report of the Special Committee on Reentry to Practice (HOD 2012) defines the clinically active physician as one who, at the time of license renewal, is engaged in direct, consultative, or supervisory patient care, or as further defined by the states. Clinically inactive physician is defined as one who is not engaged in direct, consultative or supervisory patient care at the time of license renewal, but who, as a result of their professional activities, influences the care provided by clinically active practitioners.

519 years of an un-expired term should be considered to have served a full term.

520 Terms of service should be staggered, one fourth of the Board's membership being appointed each year.

521 In order to ensure there is continual representation of public members, for Boards with up to four public  
522 members, the term of no more than one public member should expire in any one year. For Boards with  
523 more than four public members, the terms of no more than two public members should expire in any  
524 one year.

## 525 Requirements

526 Before assuming the duties of office, the following should be required of each member of the Board:

- 527 1. Take a constitutional oath or affirmation of office;
- 528 2. Swear or affirm that he/she is qualified to serve under all applicable statutes;
- 529 3. Sign a statement agreeing that he/she will disclose any potential conflicts of interest that may  
530 arise for that member in the conduct of Board business;
- 531 4. Sign a confidentiality and ethics statement agreeing to maintain the confidentiality of  
532 confidential Board business and patient identification and uphold high ethical standards in  
533 discharging Board duties.

534 The Board should also conduct, and new members should attend, a training program designed to  
535 familiarize new members with their duties and ethics of public service. The Board should hold an annual  
536 training program for new members.

## 537 Appointment

538 The members of the Board should be appointed by the Governor, who should make each appointment  
539 at least 30 calendar days prior to the beginning of the Board term being filled. The Governor should fill  
540 an unexpired term within 30 calendar days of the vacancy's occurrence. The incumbent should serve  
541 until the Governor names a replacement. Should the Governor not act as such, the Board, by majority  
542 vote, should select a qualified person to serve in the interim until the Governor acts. Any individual,  
543 organization or group should be permitted to suggest potential Board appointees to the Governor.

## 544 Removal

545 A Board member should be automatically removed from the Board if the Board member:

- 546 1. Ceases to be qualified;
- 547 2. Submits written resignation to the Board Chair or to the Governor;
- 548 3. Is absent from the state for a period of more than six months;
- 549 4. Is found guilty of a felony or an unlawful act involving moral turpitude by a court of competent  
550 jurisdiction;
- 551 5. Is found guilty of malfeasance, misfeasance, or nonfeasance in relation to the Board member's  
552 Board duties by a court of competent jurisdiction;
- 553 6. Is found to be mentally incompetent by a court of competent jurisdiction;
- 554 7. Fails to attend three successive Board meetings without just cause as determined by the Board,

- 555 or, if a new member, fails to attend the new members' training program without just cause as  
556 determined by the Board;
- 557 8. Is found to be in violation of the medical practice act; or  
558 9. Is found to be in violation of the conflict of interest/ethics law.

## 559 Compensation/Reimbursement

560 Members of the Board should receive appropriate compensation for services and reimbursement for  
561 expenses at the respective state's current approved rate.

- 562 • Compensation: Service on the Board should not present an undue economic hardship. Board  
563 members should therefore receive compensation in an amount sufficient to allow full  
564 participation and not preclude qualified individuals from serving.
- 565 • Expenses: Each Board member's travel and expenses necessarily and properly incurred for  
566 active Board service should be paid at the respective state's current approved rate.
- 567 • Education/Training: Travel, expenses, and daily compensation should also be paid for each  
568 Board member's attendance, in or out of the Board's jurisdiction, for education or training  
569 purposes approved by the Board and directly related to Board duties.

## 570 Section V. State Medical Board Structure

### 571 Officers

572 The Board should elect annually from its members a president/chair, a vice president/vice- chair, a  
573 secretary-treasurer, and those other officers it determines are necessary to conduct its business. The  
574 officers shall serve for a one-year term.

- 575 • President/Chair: The president/chair should approve Board meeting agendas, preside at Board  
576 meetings, appoint Board committees and their chairs, and perform those other duties assigned  
577 by the Board and this statute.
- 578 • Vice President/Vice-Chair: The vice president/vice-chair should assist the president/chair in all  
579 duties as requested by the president/chair and should perform the duties of the president/chair  
580 in that officer's absence.
- 581 • Secretary/Treasurer: The secretary-treasurer should ensure the maintenance of the minutes of  
582 all meetings of the Board and that the expenditure of funds complies with respective state law.

### 583 Committees

584 To effectively facilitate its work, fulfill its duties and exercise its powers, the Board should be authorized  
585 to appoint committees from its membership, establish standing committees, including, but not limited  
586 to, licensing, investigation, finance, administration, personnel, rules, legislative communications, and  
587 public information committees. The chair should also be empowered to name ad hoc committees as  
588 required. Changes in membership should not be deemed to affect or hinder the continuing business or  
589 activity of any committee.

590 Other committees created by the Board should have responsibilities, consistent with the medical

591 practice act, delegated to them by the Board.

## 592 Funding

593 The medical practice act should provide that Board fees be adequate to fund the Board's ability to  
594 effectively regulate the practice of medicine under the act, and that those fees paid by licensees be used  
595 only for purposes related to licensee licensure, discipline, education and Board administration. A  
596 designated officer of the Board or employee, at the direction of the Board, should oversee the collection  
597 and disbursement of funds, and the State Auditor's Office (or the equivalent State office) should  
598 routinely audit the financial records of the Board and report to the Board and the Legislature.

## 599 Revenues

600 The Board should be fully supported by the revenues generated from its activities, including fees,  
601 charges and reimbursed costs, which the Board should deposit in an appropriate account, and the Board  
602 should also receive all interest earned on the deposit of such revenues. Such funds should be  
603 appropriated continuously and used by the Board only for administration and enforcement of the  
604 medical practice act. All fines levied by the Board may be deposited in the State General Fund, unless  
605 otherwise allowed by law. All administrative, investigative and adjudicatory costs recoupment should be  
606 deposited in the Board's account.

607 In the event the legislature imposes additional responsibilities on the Board beyond the Board's  
608 statutory responsibilities for licensure and discipline, the legislature should appropriate additional funds  
609 to the Board sufficient to carry out such additional responsibilities.

## 610 Budget

611 The Board should develop and adopt its own budget reflecting revenues, including the interest thereon,  
612 and costs associated with each health care field regulated. Revenues and interest thereon, from each  
613 health care field regulated should fully support Board regulation of that field. The budget should include  
614 allocations for establishment and maintenance of a reasonable reserve fund.

## 615 Setting Fees and Charges

616 All Board fees and charges should be set by the Board pursuant to its proposed budget needs. The Board  
617 should provide reasonable notice to the regulated healthcare professional and the public of all increases  
618 or decreases in fees and charges.

## 619 Fiscal Year

620 The Board should operate on the same fiscal year as the State.

## 621 Section VI. Meetings of the Board and Committee of the Board

### 622 Location

623 The Board and its committees should meet in the Board's offices, or other appropriate facilities in the  
624 same city as those offices. At their discretion, however, they may meet from time to time in other areas  
625 of the State to facilitate their work or to enhance communication with the public and members of the  
626 regulated professions.

627 Telephone or other telecommunication conference is an acceptable form of Board meeting if the  
628 president/chair alone or another officer and two Board members believe the Board's business can be  
629 properly conducted by teleconference. The Board should be authorized to establish procedures by  
630 which its committees may meet by telephone or other telecommunication conference system.

### 631 **Frequency, Duration**

632 The Board should meet at least bimonthly for a period sufficient to complete the work before it at that  
633 time. One meeting per quarter may be sufficient for states with small physician populations.  
634 Committees should meet as directed by the Board.

### 635 **Special Meetings, Conferences**

636 Emergency meetings of the Board may be called at any time by the president/chair or at the request of  
637 an officer and two Board members if required to enforce the medical practice act. The Board may  
638 establish procedures by which its committees may call emergency meetings in accordance with the  
639 State's open meeting laws.

640 Informal conferences of an investigation committee may be called by the chair of the committee for the  
641 purpose of holding discussions with licensees, accused or otherwise, who seek or agree to such  
642 conferences. Any disciplinary action taken as a result of such a conference and agreed to in writing by  
643 the Board and licensee should be binding and a matter of public record. The holding of an informal  
644 conference should be at an investigation committee's discretion and should not preclude formal  
645 disciplinary investigation, proceedings, or action.

### 646 **Notice**

647 The Board should establish a system for giving all Board and committee members reasonable notice of  
648 all Board and committee meetings. The Board should comply with the State's open meeting laws.

### 649 **Quorum**

650 A majority of members constitutes a quorum for the transaction of business by the Board or any  
651 committee of the Board. The business of the Board and its committees should be conducted in accord  
652 with the medical practice act and with rules of parliamentary procedure adopted by the Board.

### 653 **Conflict of Interest**

654 No member of the Board, acting in that capacity or as a member of any Board committee, shall  
655 participate in the deliberation, making of any decision, or the taking of any action affecting the Board  
656 member's own personal, professional, or pecuniary interest, or that of a known relative or of a business  
657 or professional associate. With advice of legal counsel, the Board shall adopt and annually review a  
658 conflict of interest policy to enforce this section.

### 659 **Minutes**

660 Minutes of all Board and committee meetings and proceedings, and other Board and committee  
661 materials, shall be prepared and kept in accord with the Board's adopted rules of parliamentary  
662 procedure and other applicable State laws.

663 **Open Meetings**

664 All meetings of the Board and its committees should be open to the public in accordance with the  
665 State’s Open Meeting laws, with the following exceptions:

- 666 1. Meetings or portions of meetings of the Board, acting in its capacity as a hearing or adjudicatory  
667 body, held to receive testimony or evidence the public disclosure of which the Board determines  
668 would constitute an unreasonable invasion of personal privacy, to consult with legal counsel, to  
669 deliberate issues, and to arrive at disciplinary judgments;
- 670 2. Meetings or portions of meetings regarding investigations;
- 671 3. Meetings or portions of meetings regarding license applications; and
- 672 4. Meetings or portions of meetings regarding personnel actions.

673 The Board should ratify all recommendations or decisions made in nonpublic meetings in public, which  
674 should be matters of public record.

675 **Confidentiality**

676 The minutes and all records of nonpublic meetings are privileged and confidential and should not be  
677 disclosed, except to the Board or its designees for the enforcement of the medical practice act, except  
678 that all licensing decisions made by the Board and all disciplinary orders, with the associated findings of  
679 fact and conclusions of law and order, issued by the Board should be matters of public record.

680 The following should be privileged and confidential:

- 681 1. Application and renewal forms and any evidence submitted in proof or support of an application  
682 to practice, except that the following items of information about each applicant or licensee  
683 included on such forms should be matters of public record:
  - 684 a. Full name;
  - 685 b. Date of birth;
  - 686 c. Name(s) and location(s) of professional schools attended;
  - 687 d. School awarding professional degree, date of award, and designation of degree;
  - 688 e. Site(s) and date(s) of graduate certification(s) held and date(s) granted;
  - 689 f. Specialty certifications;
  - 690 g. Year of initial licensure in the State;
  - 691 h. Other states in which licensed to practice; and
  - 692 i. Current office address and telephone number.
- 693 2. All investigations and records of investigations;
- 694 3. Any report from any source concerning the fitness of any person to receive or hold a license;
- 695 4. Any communication between or among the Board and/or its committees, staff, advisors,  
696 attorneys, employees, hearing officers, consultants, experts, investigators and panels occurring  
697 outside public meetings; and
- 698 5. A complaint and the identity of an individual or entity filing an initial complaint with the Board.

699 Notwithstanding the foregoing provisions, the Board may cooperate with and provide documentation to

700 other boards, agencies or law enforcement bodies of the State, other states, other jurisdictions, or the  
701 United States upon written official request by such entity(s). The Board should share investigative  
702 information at the early stages of a complaint investigation in order to reduce the likelihood that a  
703 licensee may become licensed in one state while under investigation in another state.

704 These provisions should not be construed as prohibiting a respondent or the respondent's legal counsel  
705 from exercising the respondent's right of due process under the law.

## 706 Section VII. Administration of the State Medical Board

### 707 Offices

708 The Board should maintain offices it determines are adequate in size, staff, and equipment to effectively  
709 carry out the provisions of the medical practice act. At its discretion, it may establish branch offices,  
710 staffed and equipped as it finds necessary, in as many areas of the State as it believes require such  
711 branch offices to facilitate the work of the Board.

### 712 Administration

713 The Board should set out the function, operation, and administration structure of its offices.

### 714 Staff, Special Personnel

715 To effectively perform its duties under the medical practice act, the Board should be empowered to  
716 determine its staff needs and to employ, fix compensation for, evaluate, discipline, and remove its own  
717 full-time, part-time and temporary staff in accord with the statutory requirements of the State. The  
718 Board should also be assigned adequate legal counsel by the office of the attorney general and/or be  
719 authorized to employ private counsel or its own full-time attorney. The Board should define the duties  
720 of and qualifications for the executive director. Staff benefits should be provided in accord with the  
721 statutes of the State.

722 The Board's staff may include, but need not be limited to, the following:

- 723 • An executive director, who, among administrative and other delegated responsibilities, may  
724 assist, at the Board's discretion, in the discharge of the duties of the secretary-treasurer and if  
725 one exists, the licensing committee, the investigation committee, and any other standing or ad  
726 hoc committee;
- 727 • One or more assistant executive directors;
- 728 • One or more medical consultants, who shall be licensed to practice medicine in the State  
729 without restriction;
- 730 • Office and clerical staff;
- 731 • One or more attorneys, who may be full-time employees of the Board, contractors of the Board,  
732 or assigned from the Office of the State Attorney General by agreement between the Board and  
733 that office, or in private practice; and/or
- 734 • One or more investigators, who shall be trained in and knowledgeable about the investigation of  
735 medical and related health care practice.

## 736 Special Support Personnel

737 The Board may enlist, at its discretion, the services of experts, advisors, consultants, and others who are  
738 not part of its staff to assist it in more effectively enforcing the medical practice act. Such persons may  
739 serve voluntarily, be reimbursed for expenses in accord with State law and policy, or be compensated at  
740 a level commensurate with services rendered in accord with state law and policy. When acting for or on  
741 behalf of the Board, such persons should benefit from the same immunity and indemnification  
742 protections afforded by this statute to the members and staff of the Board.

## 743 Section VIII. Immunity, Indemnity, Protected Communication

744 The medical practice act should provide legal protection for the members of the Board and its staff and  
745 for those providing information to the Board in good faith.

### 746 Immunity

747 There shall be no liability, monetary or otherwise, on the part of, and no cause of action for damages  
748 shall arise against any current or former member, officer, administrator, staff member, committee  
749 member, examiner, representative, agent, employee, consultant, witness, or any other person serving  
750 or having served the Board, either as a part of the Board's operation or as an individual, as a result of  
751 any act, omission, proceeding, conduct, or decision related to the duties undertaken or performed in  
752 good faith and within the scope of the function of the Board.

### 753 Qualified Immunity and Indemnity

754 The medical practice act should provide the following:

- 755 1. There shall be no liability on the part of, and no action for damages against, any member of the  
756 Board, its agents, its employees, or any member of an examining committee of physicians  
757 appointed or designated by the Board, for any action undertaken or performed by such person  
758 within the scope of the duties, powers, and functions of the Board or such examining committee  
759 when such person is acting in good faith and in the reasonable belief that the action taken by  
760 such person is warranted.
- 761 2. If a current or former member, officer, administrator, staff member, committee member,  
762 examiner, representative, agent employee, consultant, or any other person serving or having  
763 served the Board requests the State to defend them against any claim or action arising out of  
764 any act, omission, proceeding, conduct, or decision related to their duties undertaken or  
765 performed in good faith in furtherance of the purposes of the medical practice act and within  
766 the scope of the function of the Board, and if such a request is made in writing at a reasonable  
767 time before trial, and if the person requesting defense cooperates in good faith in the defense  
768 of the claim or action, the State shall provide and pay for such defense and shall pay any  
769 resulting judgment, compromise, or settlement.
- 770 3. No person, committee, association, organization, firm, or corporation providing information to  
771 the Board in good faith and in the reasonable belief that such information is accurate and,  
772 whether as a witness or otherwise, shall be held, by reason of having provided such information,  
773 to be liable in damages under the law of the state or any political subdivision thereof.

- 774 4. In any suit brought against the Board, its employees or agents, any member of an examining  
775 committee appointed by the Board or any person, firm, or other entity providing information to  
776 the Board, when any such defendant substantially prevails in such suit, the court shall, at the  
777 conclusion of the action, award to any such substantially prevailing party defendant against  
778 any such claimant the cost of the suit attributable to such claim, including a reasonable  
779 attorney's fee, if the claim was frivolous, unreasonable, without foundation, or in bad faith. For  
780 the purposes of this Section, a defendant shall not be considered to have substantially prevailed  
781 when the plaintiff obtains an award for damages or permanent injunctive or declaratory relief.
- 782 5. There shall be no liability on the part of and no action for damages against any corporation,  
783 foundation, or organization that enters into any agreement with the Board related to the  
784 operation of any committee or program to identify, investigate, counsel, monitor, or assist any  
785 licensed physician who suffers or may suffer from alcohol or substance abuse or a physical or  
786 mental condition which could compromise such physician's fitness and ability to practice  
787 medicine with reasonable skill and safety to patients, for any investigation, action, report,  
788 recommendation, decision, or opinion undertaken, performed, or made in connection with or  
789 on behalf of such committee or program, in good faith, and in the reasonable belief that such  
790 investigation, action, report, recommendation, decision, or opinion was warranted.
- 791 6. There shall be no liability on the part of and no action for damages against any person who  
792 serves as a director, trustee, officer, employee, consultant, or attorney for or who otherwise  
793 works for or is associated with any corporation, foundation, or organization that enters into any  
794 agreement with the Board related to the operation of any committee or program to identify,  
795 investigate, counsel, monitor, or assist any licensed physician who suffers or may suffer from  
796 alcohol or substance abuse or a physical or mental condition which could compromise such  
797 physician's fitness and ability to practice medicine with reasonable skill and safety to patients,  
798 for any investigation, action, report, recommendation, decision, or opinion undertaken,  
799 performed, or made in connection with or on behalf of such committee or program, in good  
800 faith and in the reasonable belief that such investigation, action, report, recommendation,  
801 decision, or opinion was warranted.
- 802 7. In any suit brought against any corporation, foundation, organization, or person described in  
803 Subsection 4 or 5 of this Section, when any such defendant substantially prevails in the suit, the  
804 court shall, at the conclusion of the action, award to any substantially prevailing party defendant  
805 against any claimant the cost of the suit attributable to such claim, including reasonable  
806 attorney fees, if the claim was frivolous or brought without a reasonable good faith basis. For  
807 purposes of this Subsection, a defendant shall not be considered to have substantially prevailed  
808 when the plaintiff obtains a judgment for damages, permanent injunction, or declaratory relief.
- 809 8. The state should defend a current or former member, officer, administrator, staff member,  
810 committee member, examiner, representative, agent, employee, consultant, witness,  
811 contractor, or any other person serving or having served the Board against any claim or action  
812 arising out of the medical practice act, omission, proceeding, conduct, or decision related to the  
813 person's duties undertaken or performed in good faith and within the scope of the function of  
814 the Board. The State should provide and pay for such defense and should pay any resulting  
815 judgment, compromise, or settlement.

## 816 Protected Communication

817 Every communication made by or on behalf of any person, institution, agency, or organization to the  
818 Board or to any person designated by the Board, relating to an investigation or the initiation of an  
819 investigation, whether by way of report, complaint, or statement, should be privileged. No action or  
820 proceeding, civil or criminal, should be permitted against any such person, institution, agency, or  
821 organization by whom or on whose behalf such a communication was made in good faith.

822 The protections afforded in this provision should not be construed as prohibiting a respondent or the  
823 respondent's legal counsel from exercising the respondent's constitutional right of due process under  
824 the law.

## 825 Section IX. Reports of the Board

### 826 Annual Report

827 The Board should present to the Governor, the Legislature and the public, at the end of each fiscal year,  
828 a formal report summarizing its licensing and disciplinary activity for that year. The report should  
829 include, but not limited to, the following information about each of the Board's regulated professions:

- 830 1. The total number of persons fully licensed by the State and the number of those licensees  
831 currently practicing in the State;
- 832 2. The number of licensees holding each form of limited license authorized by this statute;
- 833 3. The number of persons granted a full license by the State for the first time in the past year, the  
834 number of those licensees currently practicing in the State, and the number of full licenses  
835 denied in the past year;
- 836 4. The number of licensees currently practicing in-state about whom a complaint, a charge or an  
837 adverse item of information required by law was received in the past year;
- 838 5. The number and the source, by category, of complaints, charges and adverse items of  
839 information required by law received about licensees practicing in-state in the past year and the  
840 number of these found not to warrant action under this statute and the rules of the Board;
- 841 6. The number of disciplinary investigations conducted by the Board or its representatives  
842 concerning licensees practicing in-state in the past year;
- 843 7. The number of disciplinary actions, by category, taken by the Board in the past year against all  
844 licensees;
- 845 8. A ranking, by frequency, of primary causes for disciplinary action against all licensees in the past  
846 year;
- 847 9. A review of disciplinary activity related to holders of limited forms of license in the past year;
- 848 10. A review of the operations of the Board's current mechanisms for dealing with a licensee  
849 dependent on or addicted to alcohol or other addictive substances which have the potential to  
850 impair;
- 851 11. A schedule of all current fees and charges;
- 852 12. A revenue and expenditure statement for the past year indicating the percentage of revenue  
853 from and expenditures for each regulated profession;
- 854 13. A summary of other Board activities and a schedule of days met by the Board and each of its

- 855 committees during the year;
- 856 14. A summary of administrative and legislative activity in the past year;
- 857 15. A summary of the goals and objectives established by the Board for the coming fiscal year; and
- 858 16. A copy of the Board's strategic plan.

## 859 Public Record, Action Reports

860 Each of the Board's non-administrative license application withdrawals, license denials and final  
861 disciplinary orders, including any associated findings of fact and conclusions of law, should be matters of  
862 public record. Voluntary surrenders of or limitations on licenses shall also be matters of public record.  
863 The Board should promptly report all denials, orders, surrenders, and limitations to the public, all health  
864 care institutions in the State, appropriate State and federal agencies, related professional societies or  
865 associations in the State, and any data repository. The Board should make the information readily  
866 accessible to the public via the physician's profile. The Board should update the profile at least annually  
867 and offer the licensee an opportunity to correct erroneous information. A licensee's profile shall  
868 contain, but not be limited to:

- 869 1. Demographic Information: name and license number, gender, business or practice address, and  
870 birth date.
- 871 2. Medical Education: medical school(s)' name, address, year of graduation and degree, post-  
872 graduate training program(s)' name, address, years attended, and year completed.
- 873 3. License and Board Certification Information: license status, license type, original license date,  
874 license renewal date, specialty and type of practice, and board certification by a certifying  
875 authority recognized by the Board.
- 876 4. Criminal Convictions: a description of any conviction of a felony or a misdemeanor involving  
877 moral turpitude within the last five years, including cases with a deferred adjudication or  
878 expungement.
- 879 5. Malpractice History:
  - 880 a. The number of awards or judgments within the past 10 years;
  - 881 b. When the number exceeds 3, the number of demands, claims, and/or settlements paid  
882 by the licensee or on behalf of the licensee in the past 5 years; and
  - 883 c. A statement that malpractice payments do not necessarily demonstrate the quality of  
884 care provided by a physician, and that the Board independently investigates all reports  
885 of payment in malpractice cases, which will appear in the licensee's disciplinary history if  
886 the Board completed the investigation and took disciplinary action.
- 887 6. Disciplinary History:
  - 888 a. All disciplinary actions taken by the Board;
  - 889 b. A brief description of the reason for a disciplinary action;
  - 890 c. All disciplinary actions taken by other state medical/osteopathic boards and a brief  
891 description of the reason for discipline if available;
  - 892 d. All disciplinary actions taken by hospitals;
  - 893 e. An explanation of the types of discipline the Board takes and its effects on the licensee's  
894 ability to practice; and

895 f. A statement that hospitals may take disciplinary actions for reasons that do not violate  
896 the governing statutes.

## 897 Section X. Examinations

898 The medical practice act should provide for the Board's authority to approve an examination(s) of  
899 medical knowledge satisfactory to inform the Board's decision to issue a full, unrestricted license to  
900 practice medicine and surgery in the jurisdiction.

901 In order to ensure a high quality, valid, and reliable examination of physician preparedness to practice  
902 medicine, the Board may delegate the responsibilities for examination development, administration,  
903 scoring, and security to a third party or nationally recognized testing entity. Such an examination should  
904 be consistent with recognized national standards for professional testing such as those reflected in  
905 Standards for Educational and Psychological Testing.

906 No person should receive a license to practice medicine in the jurisdiction unless he or she has  
907 successfully completed all components of an examination(s) identified as satisfactory to the Board:

- 908 • The currently administered United States Medical Licensing Examination (USMLE) Steps 1,2,3 or  
909 The Comprehensive Osteopathic Medical Licensing Examination of the United States (COMLEX-  
910 USA) Levels 1,2,3; or
- 911 • Previously administered examinations such as the Federation Licensing Examination (FLEX),  
912 National Board of Medical Examiners (NBME) Parts or National Board of Osteopathic Medical  
913 Examiners (NBOME) Parts; or
- 914 • A combination of these examinations identified as acceptable by the Board.

915 The examination(s) approved by the Board should be in the English language and designed to ascertain  
916 an individual's fitness for an unrestricted license to practice medicine and surgery.

917 The Board may stipulate the numeric score or performance level required for passing the examination(s)  
918 or accept the recommended minimum passing score as determined by the developers of the  
919 examination.

920 The Board should be authorized to limit the number of times an examination may be taken, to require  
921 applicants to pass all examinations within a specified period, and to specify further medical education  
922 required for applicants unable to do so.

923 In order to support periodic or mandated reviews of its approved examination(s), the Board should be  
924 provided with reasonable access by the third party or testing entity in order to review the examination  
925 design, format, and content, as well as performance data and relevant procedures for test  
926 administration, security, and scoring.

## 927 Section XI. Requirements for Full Licensure

928 The medical practice act should provide minimum requirements for full licensure for the independent  
929 practice of medicine that bear a reasonable relationship to the qualifications and fitness necessary for

930 such practice. These provisions of the act should implement or be consistent with the following:

- 931 1. The applicant should provide the Board, or its agent, and attest to, or provide the means to  
932 obtain and verify the following information and documentation in a manner required by the  
933 Board:
- 934 a. The applicant's full name and all aliases or other names ever used, current address,  
935 Social Security number, and date and place of birth;
  - 936 b. A signed photograph not more than two (2) years old and, at the Board's discretion,  
937 other documentation of identity;
  - 938 c. Originals of all documents and credentials required by the Board, notarized  
939 photocopies, or other verification acceptable to the Board of such documents and  
940 credentials;
  - 941 d. A list of all jurisdictions, United States or foreign, in which the applicant is licensed or  
942 has ever applied for licensure to practice medicine or is authorized or has ever applied  
943 for authorization to practice medicine, including all jurisdictions in which any license  
944 application or authorization has been withdrawn;
  - 945 e. A list of all jurisdictions, United States or foreign, in which the applicant has been denied  
946 licensure or authorization to practice medicine or as any other health care professional  
947 or has voluntarily surrendered a license or an authorization to practice medicine or as  
948 any other health care professional;
  - 949 f. A list of all sanctions, judgments, awards, settlements, or convictions against the  
950 applicant in any jurisdiction, United States or foreign, that would constitute grounds for  
951 disciplinary action under the medical practice act or the Board's rules and regulations;
  - 952 g. A detailed educational history, including places, institutions, dates, and program  
953 descriptions of all the applicant's education including all college, pre-professional,  
954 professional, and professional postgraduate education;
  - 955 h. A detailed chronological life history, including places and dates of residence,  
956 employment, and military service (United States or foreign) including periods of absence  
957 from the active practice of medicine;
  - 958 i. All Web sites associated with the applicant's practice and professional activities;
  - 959 j. A list and current status of all specialty certifications and the name of certifying  
960 organization; and
  - 961 k. Any other information or documentation the Board determines necessary.
- 962 2. The applicant should possess the degree of Doctor of Medicine or Doctor of Osteopathic  
963 Medicine/Doctor of Osteopathy from a medical college or school located in the United States,  
964 its territories or possessions, or Canada that was approved by the Board or by a private  
965 nonprofit accrediting body approved by the Board at the time the degree was conferred. No  
966 person who graduated from a medical school that was not approved at the time of graduation  
967 should be examined for licensure or be licensed in the jurisdiction based on credentials or  
968 documentation from that school nor should such a person be licensed by endorsement.
- 969 3. Should the applicant graduate from a medical school in a foreign country, other than Canada,  
970 the applicant should meet all the requirements established by the Board to determine the

- 971 applicant's fitness to practice medicine.
- 972 4. The applicant should have satisfactorily completed at least thirty-six (36) months of progressive
- 973 postgraduate medical training (also termed graduate medical education, or GME) accredited by
- 974 the Board, the Accreditation Council for Graduate Medical Education (ACGME), or the American
- 975 Osteopathic Association (AOA).
- 976 5. The applicant should have passed the USMLE Steps 1, 2, 3 or COMLEX Levels 1, 2, 3 or a
- 977 predecessor examination (FLEX, NBME Parts, NBOME Parts) or a combination of these
- 978 examinations identified as accredited by the Board.
- 979 6. The applicant should have demonstrated a familiarity with the statutes and regulations of the
- 980 jurisdiction relating to the practice of medicine and the appropriate use of controlled or
- 981 dangerous substances.
- 982 7. The applicant should be physically, mentally, and professionally capable of practicing medicine
- 983 in a manner acceptable to the Board and should be required to submit to a physical, mental,
- 984 professional competency, or chemical dependency examination(s) or evaluation(s) if deemed
- 985 necessary by the Board.
- 986 8. The applicant should not have been found guilty by a competent authority, United States or
- 987 foreign, of any conduct that would constitute grounds for disciplinary action under the
- 988 regulations of the Board or the act. The Board may be authorized, at its discretion, to modify
- 989 this restriction for cause, but it should be directed to use such discretionary authority in a
- 990 consistent manner.
- 991 9. If the applicant's license is denied or in accordance with Board policy, the applicant should be
- 992 allowed a personal appearance before the Board or a representative thereof for interview,
- 993 examination or review of credentials. At the discretion of the Board, the applicant should be
- 994 required to present the applicant's original medical education credentials for inspection at the
- 995 time of personal appearance.
- 996 10. The applicant should be held responsible for verifying to the satisfaction of the Board the
- 997 validity of all credentials required for the applicant's medical licensure. The Board or its agent
- 998 should verify medical licensure credentials directly from primary sources, and utilize recognized
- 999 national physician information services (e.g., the Federation of State Medical Boards' Physician
- 1000 Data Center (PDC), which includes its Board Action Data Bank, and Federation Credentials
- 1001 Verification Service (FCVS); the files of the American Medical Association and the American
- 1002 Osteopathic Association; and other national data banks and information resources.)
- 1003 11. The applicant should have paid all fees and have completed and attested to the accuracy of all
- 1004 application and information forms required by the Board before the Board's verification process
- 1005 begins. The Board should require the applicant to authorize the Board to investigate and/or
- 1006 verify any information provided to it on the licensure application.
- 1007 12. Applicants should have satisfactorily passed a criminal background check.
- 1008 13. Pay appropriate fees.

## 1009 **Graduates of Foreign Medical Schools**

1010 The medical practice act should provide minimum requirements, in addition to those otherwise  
1011 established, for full licensure of applicants who are graduates of schools located outside the United

1012 States, its territories or possessions, or Canada. These provisions of the act should implement or be  
1013 consistent with the following:

- 1014 1. Such applicants should possess the degree of Doctor of Medicine, Bachelor of Medicine, or a  
1015 Board-approved equivalent based on satisfactory completion of educational programs  
1016 acceptable to the Board.
- 1017 2. Such applicants should be eligible by virtue of their medical education, training, and  
1018 examination for unrestricted licensure or authorization to practice medicine in the country in  
1019 which they received that education and training.
- 1020 3. Such applicants should have passed an examination acceptable to the Board that adequately  
1021 assesses the applicants' medical knowledge.
- 1022 4. Such applicants should be certified by the Educational Commission for Foreign Medical  
1023 Graduates or its Board-approved successor(s), or by an equivalent Board-approved entity.
- 1024 5. Such applicants should have a demonstrated command of the English language satisfactory to  
1025 the Board.
- 1026 6. Such applicants should have satisfactorily completed at least thirty-six (36) months of  
1027 progressive post-graduate medical training accredited by the Board, the Accreditation Council  
1028 for Graduate Medical Education (ACGME), or the American Osteopathic Association (AOA).
- 1029 7. All credentials, diplomas, and other required documentation in a foreign language submitted to  
1030 the Board by or on behalf of such applicants should be accompanied by certified English  
1031 translations acceptable to the Board.
- 1032 8. Such applicants should have satisfied all applicable requirements of the United States  
1033 Immigration and Naturalization Service.

## 1034 Section XII. Licensure by Endorsement, Expedited Licensure by 1035 Endorsement, and Temporary and Special Licensure

1036 The medical practice act should provide for licensure by endorsement, expedited licensure by  
1037 endorsement, and in certain clearly defined cases, for temporary and special licensure.

### 1038 Endorsement for Licensed Applicants

1039 The Board should be authorized, at its discretion, to issue a license by endorsement to an applicant who:

- 1040 1. Has complied with all current medical licensing requirements save that for examination  
1041 administered by the Board;
- 1042 2. Has passed a medical licensing examination given in English by another state, the District of  
1043 Columbia, or a territory or possession of the United States or Canada, provided the Board  
1044 determines that examination was equivalent to its own current examination, or an independent  
1045 testing agent designated by the Board; and
- 1046 3. Has a valid current medical license in another state, the District of Columbia, or a territory or  
1047 possession of the United States or Canada.

1048 **Expedited Licensure by Endorsement**

1049 The Board should be authorized, at its discretion, to issue an expedited license by endorsement to an  
1050 applicant who provides documentation of:

- 1051 1. Identity as required by the Board;
- 1052 2. All jurisdictions in which the applicant holds a full and unrestricted license;
- 1053 3. Graduation from an approved medical school:
- 1054 a. Liaison Committee on Medical Education (LCME) or Commission on Osteopathic College  
1055 Accreditation (COCA) of the American Osteopathic Association (AOA) approved medical  
1056 school;
- 1057 b. Fifth Pathway certificate; or
- 1058 c. Educational Commission for Foreign Medical Graduates (ECFMG) certificate.
- 1059 4. Passing one or more of the following examinations acceptable for initial licensure within three  
1060 attempts per step/level:
- 1061 a. United States Medical Licensing Examination (USMLE) Steps 1-3 or its predecessor  
1062 examinations, the National Board of Medical Examiners (NBME) I-III or the Federation  
1063 Licensing Examination (FLEX);
- 1064 b. Comprehensive Osteopathic Medical Licensure Examination (COMLEX-USA) Levels 1-3 or  
1065 its predecessor examinations, the National Board of Osteopathic Medical Examiners  
1066 Levels 1-3 or its predecessor examination(s); and/or
- 1067 c. Medical Council of Canada Qualifying Examinations (MCCQE) or its predecessor  
1068 examination(s) offered by the Licentiate Medical Council of Canada.
- 1069 5. Successful completion of the total examination sequence within seven (7) years, except when in  
1070 combination with a Ph.D. program;
- 1071 6. Successful completion of three (3) years of progressive postgraduate training in a program  
1072 accredited by the Accreditation Council on Graduate Medical Education (ACGME) or the AOA;  
1073 and/or
- 1074 7. Certification or recertification by a medical specialty board recognized by the American Board of  
1075 Medical Specialties (ABMS) or the AOA within the previous ten (10) years. Lifetime certificate  
1076 holders who have not passed a written specialty recertification examination must demonstrate  
1077 successful completion of the Special Purpose Examination (SPEX), Comprehensive Osteopathic  
1078 Medical Variable Purpose Examination (COMVEX) or applicable specialty recertification  
1079 examination.

1080 Boards should obtain supplemental documentation including, but not limited to:

- 1081 1. Criminal background check;
- 1082 2. Absence of current/pending investigations in any jurisdiction where licensed;
- 1083 3. Verification of specialty board certification; and
- 1084 4. Professional experience.

1085 Physicians desiring an expedited process for licensure may utilize the Federation Credentials Verification  
1086 Service (FCVS), or credentials verification meeting equivalent standards for verification of core

1087 credentials, or rely on the primary source verification of the state board of first licensure for:

- 1088 1. Medical school diploma;
- 1089 2. Medical school transcript;
- 1090 3. Dean's certificate;
- 1091 4. Examination history;
- 1092 5. Disciplinary history;
- 1093 6. Identity (photograph and certified birth certificate or original passport);
- 1094 7. ECFMG certificate, if applicable; and
- 1095 8. Fifth Pathway certificate, if applicable, and postgraduate training verification.

### 1096 Temporary Licensure

1097 The Board should be authorized to establish regulations for issuance of a temporary medical license for  
1098 the intervals between Board meetings. Such a license should:

- 1099 1. Be granted only to an applicant demonstrably qualified for a full and unrestricted medical  
1100 license under the requirements set by the medical practice act and the regulations of the Board;  
1101 and
- 1102 2. Automatically terminate within a period specified by the Board.

### 1103 Special Licensure

1104 The Board should be authorized to issue conditional, restricted, probationary, limited or otherwise  
1105 circumscribed licenses as it determines necessary. It is up to the discretion of the state medical board to  
1106 set the criteria for issuing special purpose licenses. This provision should include, but not be limited to,  
1107 the ability to issue a special license for the following purposes:

- 1108 1. To provide medical services to a traveling sports team, coaches, and staff for the duration of the  
1109 sports event;
- 1110 2. To provide volunteer medical services to under-insured/uninsured patients;
- 1111 3. To provide medical services to youth camp enrollees, counselors, and staff for the duration of  
1112 the youth camp; and
- 1113 4. To engage in the limited practice of medicine in an institutional setting by a physician who is  
1114 licensed in another jurisdiction in the United States.

## 1115 Section XIII. Limited Licensure for Physicians in Postgraduate 1116 Training

1117 The medical practice act should provide that all physicians in all postgraduate training in the state or  
1118 jurisdiction who are not otherwise fully licensed to practice medicine should be licensed on a limited  
1119 basis for educational purposes. These provisions of the act should implement or be consistent with the  
1120 following:

- 1121 1. To be eligible for limited licensure, the applicant should have completed all the requirements for  
1122 full and unrestricted medical licensure except postgraduate training or specific examination

- 1123 requirements.
- 1124 2. Issuance of a limited license specifically for postgraduate training should occur only after the
- 1125 applicant demonstrates that he/she is accepted in a residency program. The application for
- 1126 limited licensure should be made directly to the Board in the jurisdiction where the applicant's
- 1127 postgraduate training is to take place.
- 1128 3. The Board should establish by regulation restrictions for the limited license to assure that the
- 1129 holder will practice only under appropriate supervision and within the confines of the program
- 1130 within which the resident is enrolled.
- 1131 4. The limited license should be renewable annually and upon the written recommendation of the
- 1132 supervising institution, including a written evaluation of performance, until the Board
- 1133 regulations require the achievement of full and unrestricted medical licensure.
- 1134 5. The disciplinary provisions of the medical practice act should apply to the holders of the limited
- 1135 and postgraduate training license as if they held full and unrestricted medical licensure.
- 1136 6. The issuance of a limited license should not be construed to imply that a full and unrestricted
- 1137 medical license would be issued at any future date.

### 1138 Postgraduate Training Program Reporting Requirements

1139 Program directors responsible for postgraduate training should be required annually to provide the

1140 Board a written report on the status of program participants having a limited license.

1141 The report should inform the Board about program participants who have successfully completed the

1142 program, have departed from the program, have had unusual absences from the program, or have had

1143 problematic occurrences during the course of the program.

1144 The report should include an explanation of any disciplinary action taken against a limited licensee for

1145 performance or behavioral reasons which, in the judgment of the program director, could be a threat to

1146 public health, safety, and welfare; unapproved or unexplained absences from the program; resignations

1147 from the program or nonrenewal of the program contract; dismissals from the program for performance

1148 or behavioral reasons; and referrals to substance abuse programs not approved by the Board.

1149 Failure to submit the annual program director's report shall be considered a violation of the mandatory

1150 reporting provisions of the medical practice act and shall be grounds to initiate such disciplinary action

1151 as the Board deems appropriate, including fines levied against the supervising institution and suspension

1152 of the program director's medical license.

### 1153 Section XIV: Periodic Renewal

1154 The medical practice act should provide for the periodic renewal of medical licenses to permit the Board

1155 to review the qualifications of licensees on a regular basis. These provisions of the act should implement

1156 or be consistent with the following:

1157 At the time of periodic renewal, the Board should require the licensee to demonstrate to its satisfaction

1158 the licensee's continuing qualification for medical licensure. The Board should design the application for

1159 licensure renewal to require the licensee to update and/or add to the information in the Board's file

1160 relating to the licensee and the licensee's professional activity. It should also require the licensee to  
1161 report to the Board the following information:

- 1162 1. Any action taken for acts or conduct similar to acts or conduct described in the medical practice  
1163 act as grounds for disciplinary action against a licensee by:
  - 1164 a. Any jurisdiction or authority (United States or foreign) that licenses or authorizes the  
1165 practice of medicine or participation in a payment or practice program;
  - 1166 b. Any peer review body;
  - 1167 c. Any specialty certification board;
  - 1168 d. Any health care organization;
  - 1169 e. Any professional medical society or association;
  - 1170 f. Any law enforcement agency;
  - 1171 g. Any health insurance company;
  - 1172 h. Any malpractice insurance company;
  - 1173 i. Any court; and
  - 1174 j. Any governmental agency.
- 1175 2. Any adverse judgment, settlement, or award against the licensee or payment by or on behalf of  
1176 the licensee arising from a professional liability demand, claim, or case.
- 1177 3. The licensee's voluntary surrender of or voluntary limitation on any license or authorization to  
1178 practice medicine in any jurisdiction, including military, public health, and foreign.
- 1179 4. Any denial to the licensee of a license or authorization to practice medicine by any jurisdiction,  
1180 including military, public health, and foreign.
- 1181 5. The licensee's voluntary resignation from the medical staff of any health care organization or  
1182 voluntary limitation of the licensee's staff privileges at such an organization if that action  
1183 occurred while the licensee was under formal or informal investigation by the organization or a  
1184 committee thereof for any reason related to possible medical incompetence, unprofessional  
1185 conduct, or mental, physical, alcohol, or drug impairment.
- 1186 6. The licensee's voluntary resignation or withdrawal from a national, state, or county medical  
1187 society, association, or organization if that action occurred while the licensee was under formal  
1188 or informal investigation or review by that body for any reason related to possible medical  
1189 incompetence, unprofessional conduct, mental, physical, alcohol, or drug impairment.
- 1190 7. Whether the licensee is currently suffering from any condition that adversely affects or impairs  
1191 the licensee's practice of medicine.
- 1192 8. The licensee's completion of continuing medical education or other forms of professional  
1193 maintenance and/or evaluation, including specialty board certification or recertification, within  
1194 the renewal period.

1195 The Board should be authorized, at its discretion, to require continuing medical education for license  
1196 renewal and to require documentation of that education. The Board should have the authority to audit,  
1197 randomly or specifically, licensees for compliance.

1198 The Board should require the licensee to apply for license renewal in a manner prescribed by the board  
1199 and attest to the accuracy and truthfulness of the information submitted. The Board should be

1200 authorized to collect a fee for renewal of a license.

1201 The Board should be directed to establish an effective system for reviewing renewal forms. It should  
1202 also be authorized to initiate investigations and/or disciplinary proceedings based on information  
1203 submitted by licensees for license renewal.

1204 Failure to report fully and correctly as outlined above should be grounds for disciplinary action by the  
1205 Board.

## 1206 Section XV. Disciplinary Process

1207 The medical practice act should provide for disciplinary and/or remedial action against licensees and the  
1208 grounds on which such action may be taken. These provisions of the act should implement or be  
1209 consistent with the following:

### 1210 Range of Actions

1211 A range of progressive disciplinary and remedial actions should be made available to the Board. The  
1212 Board should be authorized, at its discretion, to take disciplinary, non-disciplinary, public or non-public  
1213 actions, singly or in combination, as the nature of the violation requires and to promote public  
1214 protection. These include, but are not limited to, the following:

- 1215 1. Revocation of the medical license;
- 1216 2. Suspension of the medical license;
- 1217 3. Probation;
- 1218 4. Stipulations, limitations, restrictions, probation, and conditions relating to practice;
- 1219 5. Censure (including specific redress, if appropriate);
- 1220 6. Reprimand;
- 1221 7. Letters of concern and advisory letters:
  - 1222 a. The Board should be authorized to issue a confidential (if allowed by state law), non-  
1223 reportable, non-disciplinary letter of concern, or advisory letter to a licensee when  
1224 evidence does not warrant formal discipline, but the Board has noted indications of  
1225 possible errant conduct by the licensee that could lead to serious consequences and  
1226 formal action if the conduct were to continue. In its letter of concern or advisory letter,  
1227 the Board should also be authorized, at its discretion, to request clarifying information  
1228 from the licensee.
- 1229 8. Monetary redress to another party;
- 1230 9. A period of free public service, either medical or non-medical;
- 1231 10. Satisfactory completion of an educational, training and/or treatment program(s), or professional  
1232 developmental plan:
  - 1233 a. The Board should be authorized, at its discretion, to require professional competency,  
1234 physical, mental, or chemical dependency examination(s) or evaluation(s) of any  
1235 applicant or licensee, including withdrawal and laboratory examination of bodily fluids,  
1236 tissues, hair, or nails.
- 1237 11. Levy fines; and

1238 12. Payment of administrative and disciplinary costs.

1239 **Grounds for Action**

1240 The Board should be authorized to take disciplinary action for unprofessional or dishonorable conduct,  
1241 which should be defined to mean, but not be limited to, the following:

- 1242 1. Fraud or misrepresentation in applying for or procuring a medical license or in connection with  
1243 applying for or procuring periodic renewal of a medical license;
- 1244 2. Cheating on or attempting to subvert the medical licensing examination(s);
- 1245 3. The commission or conviction or the entry of a guilty, nolo contendere plea, or deferred  
1246 adjudication (without expungement) of:
  - 1247 a. A misdemeanor related to the practice of medicine and any crime involving moral  
1248 turpitude; or
  - 1249 b. A felony related to the practice of medicine. The Board shall revoke a licensee's license  
1250 following conviction of a felony, unless a 2/3 majority vote of the board members  
1251 present and voting determined by clear and convincing evidence that such licensee will  
1252 not pose a threat to the public in such person's capacity as a licensee and that such  
1253 person has been sufficiently rehabilitated to warrant the public trust;
- 1254 4. Conduct likely to deceive, defraud, or harm the public;
- 1255 5. Disruptive behavior and/or interaction with physicians, hospital personnel, patients, family  
1256 members, or others that interferes with patient care or could reasonably be expected to  
1257 adversely impact the quality of care rendered to a patient;
- 1258 6. Making a false or misleading statement regarding the licensee's skill or the efficacy or value of  
1259 the medicine, treatment, or remedy prescribed by the licensee or at the licensee's direction in  
1260 the treatment of any disease or other condition of the body or mind;
- 1261 7. Representing to a patient that an incurable condition, sickness, disease, or injury can be cured;
- 1262 8. Willfully or negligently violating the confidentiality between physician and patient except as  
1263 required by law;
- 1264 9. Professional incompetency as one or more instances involving failure to adhere to the  
1265 applicable standard of care to a degree which constitutes negligence, as determined by the  
1266 Board;
- 1267 10. Being found mentally incompetent or of unsound mind by any court of competent jurisdiction;
- 1268 11. Being physically or mentally unable to engage in the practice of medicine with reasonable skill  
1269 and safety;
- 1270 12. Practice or other behavior that demonstrates an incapacity or incompetence to practice  
1271 medicine;
- 1272 13. The use of any false, fraudulent, or deceptive statement in any document connected with the  
1273 practice of medicine;
- 1274 14. Giving false, fraudulent, or deceptive testimony while serving as an expert witness;
- 1275 15. Practicing medicine under a false or assumed name;
- 1276 16. Aiding or abetting the practice of medicine by an unlicensed, incompetent, or impaired person;
- 1277 17. Allowing another person or organization to the licensee's license to practice medicine;

- 1278 18. Commission of any act of sexual misconduct, including sexual contact with patient surrogates or  
1279 key third parties, which exploits the physician-patient relationship in a sexual way;
- 1280 19. Habitual or excessive use or abuse of drugs, alcohol, or other substances that impair ability;
- 1281 20. Failing or refusing to submit to an examination or any other examination that may detect the  
1282 presence of alcohol or drugs upon Board order or any other form of impairment;
- 1283 21. Prescribing, selling, administering, distributing, diverting, ordering or giving any drug legally  
1284 classified as a controlled substance or recognized as an addictive or dangerous drug for other  
1285 than medically accepted therapeutic purposes;
- 1286 22. Knowingly prescribing, selling, administering, distributing, ordering, or giving to a habitual user  
1287 or addict or any person previously drug dependent, any drug legally classified as a controlled  
1288 substance or recognized as an addictive or dangerous drug, except as otherwise permitted by  
1289 law or in compliance with rules, regulations, or guidelines for use of controlled substances and  
1290 the management of pain as promulgated by the Board;
- 1291 23. Prescribing, selling, administering, distributing, ordering, or giving any drug legally classified as a  
1292 controlled substance or recognized as an addictive drug to a family member or to the licensee  
1293 themselves;
- 1294 24. Violating any state or federal law or regulation relating to controlled substances;
- 1295 25. Signing a blank, undated, or predated prescription form;
- 1296 26. Obtaining any fee by fraud, deceit, or misrepresentation;
- 1297 27. Employing abusive, illegal, deceptive, or fraudulent billing practices;
- 1298 28. Directly or indirectly giving or receiving any fee, commission, rebate, or other compensation for  
1299 professional services not actually and personally rendered, though this prohibition should not  
1300 preclude the legal functioning of lawful professional partnerships, corporations, or associations;
- 1301 29. Disciplinary action of another state or federal jurisdiction against a license or other  
1302 authorization to practice medicine or participate in a federal program (payment or treatment)  
1303 based upon acts or conduct by the licensee similar to acts or conduct that would constitute  
1304 grounds for action as defined in this section, a certified copy of the record of the action taken by  
1305 the other state or jurisdiction being conclusive evidence thereof;
- 1306 30. Failure to report to the Board any adverse action taken against oneself by another licensing  
1307 jurisdiction (United States or foreign), by any peer review body, by any health care institution,  
1308 by any professional or medical society or association, by any governmental agency, by any law  
1309 enforcement agency, or by any court for acts or conduct similar to acts or conduct that would  
1310 constitute grounds for action as defined in this section;
- 1311 31. Failure to report or cause a report to be made to the Board of any physician upon whom a  
1312 physician has evidence or information that appears to show that the physician is incompetent,  
1313 guilty of negligence, guilty of a violation of this act, engaging in inappropriate relationships with  
1314 patients, is mentally or physically unable to practice safely, or has an alcohol or drug abuse  
1315 problem;
- 1316 32. Failure of physician who is the chief executive officer, medical officer, or medical staff to report  
1317 to the Board any adverse action taken by a health care institution or peer review body, in  
1318 addition to the reporting requirement in 31. (Note: a report under 31 may need to wait until the  
1319 peer review and due process procedures are completed, but the report under 30 must be

- 1320 reported immediately without waiting for the final action of the health care institution and  
1321 applies to all physicians not just staff physicians);
- 1322 33. Failure to report to the Board surrender of a license limitation or other authorization to practice  
1323 medicine in another state or jurisdiction, or surrender of membership on any medical staff or in  
1324 any medical or professional association or society has surrendered the authority to utilize  
1325 controlled substances issued by any state or federal agency, or has agreed to a limitation to or  
1326 restriction of privileges at any medical care facility while under investigation by any of those  
1327 authorities or bodies for acts or conduct similar to acts or conduct that would constitute  
1328 grounds for action as defined in this section;
- 1329 34. Failure to report any adverse judgment, award, or settlement against the licensee resulting from  
1330 a medical liability claim related to acts or conduct similar to acts or conduct that would  
1331 constitute grounds for action as defined in this section;
- 1332 35. Failure to report to the Board any adverse judgment, settlement, or award arising from a  
1333 medical liability claim related to acts or conduct similar to acts or conduct that would constitute  
1334 grounds for action as defined in this section;
- 1335 36. Failure to provide pertinent and necessary medical records to another physician or patient in a  
1336 timely fashion when legally requested to do so by the subject patient or by a legally designated  
1337 representative of the subject patient regardless of whether the patient owes a fee for services;
- 1338 37. Improper management of medical records, including failure to maintain timely, legible,  
1339 accurate, and complete medical records and to comply with the Standards for Privacy of  
1340 Individually Identifiable Health Information, 45 CFR Part 160 and 164, of the Health Insurance  
1341 Portability and Accountability Act of 1996;
- 1342 38. Failure to furnish the Board, its investigators, or representatives information legally requested  
1343 by the Board or failure to comply with a Board subpoena or order;
- 1344 39. Failure to cooperate with a lawful investigation conducted by the Board;
- 1345 40. Violation of any provision(s) of the medical practice act or the rules and regulations of the Board  
1346 or of an action, stipulation, or agreement of the Board;
- 1347 41. Engaging in conduct calculated to, or having the effect of, bringing the medical profession into  
1348 disrepute or conduct unbecoming of the medical profession, including but not limited to,  
1349 violation of any provision of a national code of ethics acknowledged by the Board and/or failing  
1350 to uphold the standards of the profession;
- 1351 42. Failure to follow generally accepted infection control procedures;
- 1352 43. Failure to comply with any state statute or board regulation regarding a licensee's reporting  
1353 responsibility for HIV, HVB (hepatitis B virus), seropositive status or any other reportable  
1354 condition (including child abuse and vulnerable adult abuse) or disease;
- 1355 44. Practicing medicine in another state or jurisdiction without appropriate licensure;
- 1356 45. Conduct which violates patient trust, exploits the physician-patient relationship, or violates  
1357 professional boundaries, regardless of the medium;
- 1358 46. Failure to offer appropriate procedures/studies, failure to protest inappropriate managed care  
1359 denials, failure to provide necessary service, or failure to refer to an appropriate provider within  
1360 such actions are taken for the sole purpose of positively influencing the physician's or the plan's  
1361 financial wellbeing;

- 1362 47. Providing treatment or consultation recommendations, including issuing a prescription via  
1363 electronic or other means, unless the physician has obtained a history and physical evaluation of  
1364 the patient adequate to establish diagnosis and identify underlying conditions and/or  
1365 contraindications to the treatment recommended/provided;
- 1366 48. Violating a Board formal order, condition of probation, consent agreement, or stipulation;
- 1367 49. Representing, claiming, or causing the appearance that the physician possesses a particular  
1368 medical specialty certification by a Board recognized certifying organization (ABMS, AOA) if not  
1369 true;
- 1370 50. Failing to obtain adequate patient informed consent;
- 1371 51. Using experimental treatments without appropriate patient consent and adhering to all  
1372 necessary and required guidelines and constraints;
- 1373 52. Any conduct that may be harmful to the patient or the public;
- 1374 53. Failing to divulge to the Board upon legal demand the means, method, procedure, modality, or  
1375 medicine used in the treatment of an ailment, condition, or disease;
- 1376 54. Conduct likely to deceive, defraud, or harm the public;
- 1377 55. The use of any false, fraudulent, or deceptive statement in any document connected with the  
1378 practice of the healing arts including intentional falsifying or fraudulent altering of a patient or  
1379 medical care facility record;
- 1380 56. Failure to keep written medical records which accurately describe the services rendered to the  
1381 patient, including patient histories, pertinent findings, examination results, and test results;
- 1382 57. Delegating professional responsibilities to a person when the licensee knows or has reason to  
1383 know that such person is not qualified by training, experience, or license to perform them;
- 1384 58. Using experimental forms of therapy without proper informed patient consent, without  
1385 conforming to generally accepted criteria or standard protocols, without keeping detailed  
1386 legible records, or without having periodic analysis of the study and results reviewed by a  
1387 committee or peers; and
- 1388 59. Failing to properly supervise, direct, or delegate acts which constitute the healing arts to  
1389 persons who perform professional services pursuant to such licensee's direction, supervision,  
1390 order, referral, delegation, or practice protocols.

## 1391 Enforcement and Disciplinary Action Procedures

1392 The medical practice act should provide for procedures that will permit the Board to take appropriate  
1393 enforcement and disciplinary action when and as required, while assuring fairness and due process to  
1394 licensees. These provisions of the act should implement or be consistent with the following:

1395 Board Authority: The Board should be empowered to commence legal action to enforce the provisions  
1396 of the medical practice act and to exercise full discretion and authority with respect to disciplinary  
1397 actions. In the course of an investigation, the Board's authority should include the ability to issue  
1398 subpoenas to licensees, health care organizations, complainants, patients, and witnesses to produce  
1399 documents or appear before the Board or staff to answer questions or be deposed. The Board should  
1400 have the power to enforce its subpoenas, including disciplining a non-compliant licensee, and it is  
1401 incumbent upon the subpoenaed party to seek a motion to quash the subpoena.

1402 Administrative Procedures: The existing administrative procedures act or similar statute, in whole or in  
1403 part, should either be applicable to or serve as the basis of the procedural provisions of the medical  
1404 practice act. The procedural provisions should provide for Board investigation of complaints; notice of  
1405 formal or informal charges or allegations to the licensee; a fair and impartial hearing for the licensee  
1406 before the Board, an examining committee or hearing officer; an opportunity for representation of the  
1407 licensee by counsel; the presentation of testimony, evidence and arguments; subpoena power and  
1408 attendance of witnesses; a record of the proceedings; and judicial review by the courts in accordance  
1409 with the standards established by the jurisdiction for such review. The Board should have subpoena  
1410 authority to conduct comprehensive reviews of a licensee's patient and office records and  
1411 administrative authority to access otherwise protected peer review records. The Board should not need  
1412 the patients' consent to obtain copies of medical records, nor shall health care institutions' peer-review  
1413 privilege bar the Board from obtaining copies of peer review information. Once in the Board's  
1414 possession, the patient records and peer review records should have the same legal protection from  
1415 disclosure as they have when in the possession of the licensee, the patient or the peer-review  
1416 organization.

1417 Standard of Proof: The Board should be authorized to use preponderance of the evidence as the  
1418 standard of proof in its role as trier of fact for all levels of discipline.

1419 Informal Conference: Should there be an open meeting law, an exemption to it should be authorized to  
1420 permit the Board, at its discretion, to meet in informal conference with a licensee who seeks or agrees  
1421 to such a conference. Disciplinary action taken against a licensee because of such an informal  
1422 conference and agreed to in writing by the Board and the licensee should be binding and a matter of  
1423 public record. However, license revocation and suspension should be held in open formal hearing,  
1424 unless executive session is permitted by the State's open meetings law. The holding of an informal  
1425 conference should not preclude an open formal hearing if the Board determines such is necessary.

1426 Summary Suspension: The Board should be authorized to summarily suspend or restrict a license prior  
1427 to a formal hearing when it believes such action is required to protect the public from an imminent  
1428 threat to public health and safety. The Board should be permitted to summarily suspend or restrict a  
1429 license by means of a vote conducted by telephone conference call or other electronic means if  
1430 appropriate Board officials believe such prompt action is required. Proceedings for a formal hearing  
1431 should be instituted simultaneously with the summary suspension. The hearing should be set within a  
1432 reasonable time of the date of the summary suspension. No court should be empowered to lift or  
1433 otherwise interfere with such suspension while the Board proceeds in a timely fashion.

1434 Cease and Desist Orders/Injunctions: The Board should be authorized to issue a cease-and-desist order  
1435 and/or obtain an injunction to restrain any person or any corporation or association and its officers and  
1436 directors from violating any provision of the medical practice act. Violation of an injunction should be  
1437 punishable as contempt of court. No proof of actual damage to any person should be required for  
1438 issuance of a cease-and-desist order and/or an injunction, nor should issuance of an injunction relieve  
1439 those enjoined from criminal prosecution, civil action, or administrative process for violation of the  
1440 medical practice act.

1441 Board Action Reports: All the Board’s final disciplinary actions, non-administrative license withdrawals,  
1442 and license denials, including related findings of fact and conclusions of law, should be matters of public  
1443 record. The Board should report such actions and denials to the National Practitioner Data Bank and  
1444 Board Action Data Bank of the Federation of State Medical Boards of the United States within 30 days of  
1445 the action being taken, to any other data repository required by law, and to the media. Voluntary  
1446 surrender of and voluntary limitation(s) on the medical license of any person should also be matters of  
1447 public record and should also be reported to the Federation of State Medical Boards of the United  
1448 States and to any other data repository by law. The Board should have the authority to keep confidential  
1449 practice limitations and restrictions due to physical impairment when the licensee has not violated any  
1450 provision in the medical practice act.

1451 Tolling Periods of License Suspension or Restriction: The Board should provide, in cases of license  
1452 suspension or restriction, that any time during which the disciplined licensee practices in another  
1453 jurisdiction without comparable restriction shall not be credited as part of the period of suspension or  
1454 restriction.

## 1455 Section XVI: Compulsory Reporting and Investigation

1456 The medical practice act should provide that certain persons and entities report to the Board any  
1457 possible violation of the act or of the Board’s rules and regulations by a licensee. These provisions of the  
1458 act should implement or be consistent with the following:

1459 Any person should be permitted to report to the Board in a manner prescribed by the Board, any  
1460 information he or she believes indicates a medical licensee is or may be dyscompetent, guilty of  
1461 unprofessional conduct, or mentally or physically unable to engage safely in the practice of medicine.

1462 The following should be required to report to the Board promptly and in writing any information that  
1463 indicates a licensee is or may be dyscompetent, guilty of unprofessional conduct, or mentally or  
1464 physically unable to engage safely in the practice of medicine; and any restriction, limitation, loss or  
1465 denial of a licensee’s staff privileges or membership that involves patient care:

- 1466 1. All licensees licensed under the act,
- 1467 2. All licensed health care providers,
- 1468 3. The state medical associations and its components,
- 1469 4. All hospitals and other health care organizations in the state, to include hospitals, medical  
1470 centers, long term care facilities, managed care organizations, ambulatory surgery centers,  
1471 clinics, group practices, coroners, etc.,
- 1472 5. All chiefs of staff, medical directors, department administrators, service directors, attending  
1473 physicians, residency directors, etc.,
- 1474 6. All liability insurance organizations,
- 1475 7. All state agencies,
- 1476 8. All law enforcement agencies in the state,
- 1477 9. All courts in the state,
- 1478 10. All federal agencies (e.g., Drug Enforcement Administration, Food and Drug Administration,

1479 Centers for Medicare and Medicaid Services, Veterans Health Administration, and Department  
1480 of Defense),  
1481 11. All peer review bodies in the state, and  
1482 12. All resident training program directors.

1483 A licensee's voluntary resignation from the staff of a health care organization or voluntary limitation of a  
1484 licensee's staff privileges at such an organization should be promptly reported to the Board by the  
1485 organization if that action occurs while the licensee is under formal or informal investigation by the  
1486 organization or a committee thereof for any reason related to possible medical incompetence,  
1487 unprofessional conduct, or mental, physical, alcohol or drug impairment.

1488 Malpractice insurance carriers, the licensee's attorney, a hospital, a group practice, and the affected  
1489 licensees should be required to file with the Board a report of each final judgment, settlement,  
1490 arbitration award, or any form of payment by the licensee or on the licensee's behalf by any source  
1491 upon any demand, claim, or case alleging medical malpractice, battery, dyscompetence, incompetence,  
1492 or failure of informed consent. Licensees not covered by malpractice insurance carriers should be  
1493 required to file the same information with the Board regarding themselves. All such reports should be  
1494 made to the Board promptly (e.g., within 30 days).

1495 The Board should be permitted to investigate any evidence that appears to show a licensee is or may be  
1496 medically incompetent, guilty of unprofessional conduct, or mentally or physically unable to engage  
1497 safely in the practice of medicine.

1498 Any person, institution, agency, or organization who reports in good faith and not made in bad faith, a  
1499 licensee pursuant to paragraphs 2 and 3 of this section should not be subject to civil damages or criminal  
1500 prosecution for so reporting. A bad faith report is grounds for disciplinary action under the medical  
1501 practice act. There should be no monetary liability on the part of, and no cause of action for damages  
1502 should arise against, any person, institution, agency, or organization for reporting in good faith.

1503 To assure compliance with compulsory reporting requirements, specific civil penalties should be  
1504 established for demonstrated failure to report (e.g., up to \$10,000 per instance).

1505 The Board should promptly acknowledge all reports received under this section. The Board should  
1506 promptly notify persons or entities reporting under this section of the Board's final disposition of the  
1507 matters reported.

## 1508 Section XVII. Impaired Physicians

1509 The medical practice act should provide for the limitation, restriction, conditioning, suspension or  
1510 revocation of the medical license of any licensee whose mental or physical ability to practice medicine  
1511 with reasonable skill and safety is impaired.

1512 The Board should have available to it a confidential impaired physician program approved by the Board  
1513 and charged with the evaluation and treatment of licensees who are in need of rehabilitation. The Board  
1514 may directly provide such programs or through a formalized contractual relationship with an

1515 independent entity whose program meets standards set by the Board. The Board shall have the ability  
1516 to monitor or audit the program to ensure the program meets the requirements of the Board.

1517 The Board should be authorized, at its discretion, to require a licensee or applicant to submit to a  
1518 mental or physical examination, body fluid, nail, or hair follicle test, or a chemical addiction, abuse, or  
1519 dependency evaluation conducted by an independent evaluator designated or approved in advance by  
1520 the Board. The results of the examination or evaluation should be admissible in any hearing before the  
1521 Board or hearing officer, despite any claim of privilege under a contrary rule or statute. Every person  
1522 who receives a license to practice medicine or who files an application for a license to practice medicine  
1523 should be deemed to have given consent to submit to mental or physical examination or a chemical  
1524 addition, abuse, or dependency evaluation, and to have waived all objections to the admissibility of the  
1525 results in any hearing before the Board. If a licensee or applicant fails to submit to an examination or  
1526 evaluation when properly directed to do so by the Board, the Board should be permitted to enter a final  
1527 order upon proper notice, hearing, and proof of refusal.

1528 If the Board finds, after an evaluation, examination or hearing, that a licensee is mentally, physically, or  
1529 chemically impaired, it should be authorized to take one or more of the following actions:

- 1530 1. Direct the licensee to submit to therapy, medical care, counseling, or treatment acceptable to  
1531 the Board and comply with monitoring to ensure compliance;
- 1532 2. Suspend, limit, restrict, or place conditions on the licensee's medical license for the duration of  
1533 the impairment and monitoring or treatment; and/or
- 1534 3. Revoke the licensee's medical license.

1535 Any licensee or applicant who is prohibited from practicing medicine under this provision should be  
1536 afforded, at reasonable intervals, an opportunity to demonstrate to the satisfaction of the Board that he  
1537 or she can resume or begin the practice of medicine with reasonable skill and safety. A license should  
1538 not be reinstated, however, without the payment of all applicable fees and the fulfillment of all  
1539 requirements as if the applicant had not been prohibited from practicing medicine.

1540 While all impaired licensees should be reported to the Board in accord with the mandatory reporting  
1541 requirements of the medical practice act, unidentified and unreported impaired licensees should be  
1542 encouraged to seek treatment. To this end, the Board should be authorized, at its discretion, to establish  
1543 rules and regulations for the review and approval of a medically directed Physician Health Program  
1544 (PHP). Those conducting a Board-approved PHP should be exempt from the mandatory reporting  
1545 requirements relating to an impaired licensee who is participating satisfactorily in the program, or the  
1546 Board should hold its report in confidence and without action, unless or until the impaired licensee  
1547 ceases to participate satisfactorily in the program. The Board should require a PHP to report any  
1548 impaired licensee whose participation is unsatisfactory to the Board as soon as that determination is  
1549 made. Participation in an approved PHP should not protect an impaired licensee from Board action  
1550 resulting from a report of licensee impairment from another source or resulting from an investigation of  
1551 other medical practice violations. The Board should be the final authority for approval of a PHP, should  
1552 conduct a review of its approved program(s) on a regular basis and should be permitted to withdraw or

1553 deny its approval at its discretion. The PHP should be required to report to the Board information  
1554 regarding any violation of the medical practice act by a PHP participant, other than the impairment,  
1555 even if the violation is unrelated to the licensee's impairment.

## 1556 Section XVIII: Dyscompetent and Incompetent Licensees

1557 The medical practice act should provide for the restriction, conditioning, suspension, revocation, or  
1558 denial of the medical license of any licensee who the Board determines to be dyscompetent or  
1559 incompetent. These provisions of the act should implement or be consistent with the following:

1560 The Board should be authorized to develop and implement methods to identify dyscompetent or  
1561 incompetent licensees and licensees who fail to provide the appropriate quality of care. The Board  
1562 should also be authorized to develop and implement methods to assess and improve licensee practices.

1563 The Board should have access to a Board-approved assessment program charged with assessing  
1564 licensees' clinical competency.

1565 The Board should be authorized, at its discretion, to require a licensee or an applicant for licensure to  
1566 undergo a physician competency evaluation conducted by a Board-designated independent evaluator at  
1567 licensee's own expense. The results of the assessment should be admissible in any hearing before the  
1568 Board or hearing officer, despite any claim of privilege under a contrary rule or statute. Every person  
1569 who receives a license to practice medicine or who files an application for a license to practice medicine  
1570 should be deemed to have given consent to submit to a physician competency evaluation, and to have  
1571 waived all objections to the admissibility of the results in any hearing before the Board or hearing  
1572 officer. If a licensee or applicant fails to submit to a competency assessment when properly directed to  
1573 do so by the Board, the Board should be permitted to enter a final order upon proper notice, hearing,  
1574 and proof of refusal to submit to such an evaluation.

1575 If the Board finds, after evaluation by the assessment program, that a licensee or applicant for licensure  
1576 is unable to competently practice medicine, it should be authorized to take one or more of the following  
1577 actions:

- 1578 1. Suspend, revoke, or deny the licensee's medical license or application;
- 1579 2. Restrict or limit the licensee's practice to those areas of demonstrated competence and comply  
1580 with monitoring to ensure compliance;
- 1581 3. Place conditions on the licensee's license; and/or
- 1582 4. Direct the licensee to submit to a Board approved remediation program and comply with  
1583 monitoring to ensure compliance to resolve any identified deficits in medical knowledge or  
1584 clinical skills acceptable to the Board.

1585 Any licensee or applicant for licensure who is prohibited from practicing medicine, or who has had  
1586 restrictions or conditions placed upon their license, under the above section, should be afforded, at  
1587 reasonable intervals, an opportunity to demonstrate to the satisfaction of the Board that he/she can  
1588 resume or begin the practice of medicine, or can practice without the restrictions or conditions, with  
1589 reasonable skill and safety. A license should not be reinstated, however, without the payment of all

1590 applicable fees and the fulfillment of all requirements as if the applicant had not been previously  
1591 prohibited.

1592 The Board should be authorized to require the assessment program to provide to the Board a written  
1593 report of the results of the assessment with recommendations for remediation of the identified  
1594 deficiencies.

1595 The Board should have access to Board approved remedial medical education programs for referral of  
1596 licensees in need of remediation. Such programs shall incorporate and comply with standards set by the  
1597 Board. During remediation, the program shall provide, at Board determined intervals, written reports to  
1598 the Board on the licensee's progress. Upon completion of the remediation program, the program shall  
1599 provide a written report to the Board addressing the remediation of the previously identified areas of  
1600 deficiency. The Board should be authorized to mandate that the licensee undergo post-remediation  
1601 assessment to identify areas of continued deficit. The licensee shall be responsible for all expenses  
1602 incurred as part of the assessment and the remediation.

## 1603 Section XIX: Physician Assistants

1604 The medical practice act should provide for the Board to license and regulate physician assistants.

### 1605 Administration

1606 The Board should administer and enforce these provisions of the medical practice act with the advice  
1607 and assistance of the Physician Assistant Council.

### 1608 Licensing

1609 No person should perform or attempt to practice as a physician assistant without first obtaining a  
1610 license from the Board and having a supervising physician.

1611 An applicant for licensure as a physician assistant should complete all Board application forms and pay a  
1612 nonrefundable fee. The forms should request the applicant provide their name and address and such  
1613 additional information as the Board deems necessary. The Board may issue a license to a physician  
1614 assistant applicant who fulfills all board requirements for licensure. However, a licensed physician  
1615 assistant is prohibited from practicing until they have an agreement with a supervising physician(s).

1616 Each licensed physician assistant should renew their license and file updated documentation stating  
1617 their name and current address and any additional information as required by the Board. A fee set by  
1618 the Board should accompany each renewal and filing of updated documentation.

1619 The Board may require written notification by the supervising physician and the physician assistant if the  
1620 relationship is changed or severed for a reason that would have an adverse effect for patient care.

1621 Persons not licensed by the Board who hold themselves out as physician assistants should be subject to  
1622 penalties applicable to the unlicensed practice of medicine.

1623 **Rules and Regulations**

1624 The Board should be empowered to adopt and enforce rules and regulations for:

- 1625 1. Setting qualifications of education, skill, and experience for the licensing of a person as a  
1626 physician assistant and providing forms and procedures for licensure and for renewal; and  
1627 2. Evaluating applicants for licensure as physician assistants.

1628 **Disciplinary Actions**

1629 The Board should be empowered to deny, revoke, or suspend any license, to limit or restrict the location  
1630 of practice, to issue reprimands, to remove the authorization of a supervising physician, and to limit or  
1631 restrict the practice of a physician assistant upon grounds and according to procedures similar to those  
1632 for such disciplinary actions against licensed physicians. Such actions should be reported to the National  
1633 Practitioner Databank and the Federation of State Medical Boards.

1634 **Duties and Scope of Practice**

1635 A physician assistant should be permitted to provide those medical services delegated to them by the  
1636 supervising physician that are within their training and experience.

1637 **Responsibility of Supervising Physician**

1638 Every physician supervising or employing a physician assistant should be legally responsible for the  
1639 delegation of health care tasks, the performance and the acts and omissions of the physician assistant.  
1640 Nothing in these provisions, however, should be construed to relieve the physician assistant of any  
1641 responsibility for any of their own acts and omissions. No physician should have under their supervision  
1642 more staff, physician assistant, or otherwise than the physician can adequately supervise. In the event  
1643 the supervising physician is absent, he or she must provide for appropriate supervision of the physician  
1644 assistant by another licensed physician. Each and every relationship should adhere to all statutory  
1645 requirements for licensure.

1646 **Renewal**

1647 The Board should be authorized, at its discretion, to require evidence of satisfactory completion of  
1648 continuing medical education for license renewal.

## **FSMB Advisory Council of Board Executives**

### 2017-2018 Members:

Kimberly Kirchmeyer, Medical Board of California

Kathleen Selzler Lippert, JD, CMBE Kansas State Board of Healing Arts

Maegan Carr Martin, JD, Tennessee State Board of Medical Examiners

Micah Matthews, MPA, Washington Medical Quality Assurance Commission

Frank Meyers, JD, District of Columbia Board of Medicine

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Kevin Bohnenblust, JD, President, Administrators in Medicine

Mark Bowden, MPA, CMBE, Vice President, Administrators in Medicine

Kathleen Haley, JD, CMBE, FSMB BOD, Oregon Medical Board

Ian Marquand, FSMB BOD, Montana Board of Medical Examiners

### FSMB Staff Support:

Shiri A. Hickman, JD

## REPORT OF THE BOARD OF DIRECTORS

**Subject:**                    **Report on Resolution 17-2: Advocacy for Professional Licensure of  
Emergency Medical Service Providers**

**Referred to:**            **Reference Committee A**

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In April 2017, the Federation of State Medical Boards House of Delegates referred Resolution 17-2, Advocacy for Professional Licensure of Emergency Medical Service (EMS) Providers, to the Board of Directors for study. The Resolution, submitted by the Montana Board of Medical Examiners, states:

*Resolved*, that the Federation of State Medical Boards (FSMB) adopt a position supporting professional licensure of paramedics and other advanced life support EMS providers under the authority of state medical boards; and be it further

*Resolved*, that the FSMB coordinate and collaborate with individual state medical boards and other stakeholders to develop model statutory language for states to utilize in adopting a professional licensing process and standards for EMS providers.

The Board of Directors considered the Resolution and tasked the Advisory Council of Board Executives to evaluate the regulatory oversight of paramedics and make a recommendation as to the position of the FSMB. The Board noted that the Advisory Council of Board Executives would be reviewing and recommending revisions to the *Essentials of a State Medical and Osteopathic Medical Practice Act* and the *Elements of a State Medical and Osteopathic Board* and would therefore be well positioned to study this issue and draft model statutory language, if the resolution was to be recommended for adoption.

### **Background**

Each state, territory and the District of Columbia has a lead EMS agency, according to the National Association of State Emergency Medical Services Officials (NASEMSO).<sup>i</sup> These agencies are usually a part of the state health department, but in some states they are part of a multidisciplinary state public safety department, or are an independent state agency. State EMS agencies are responsible for the overall planning, coordination, and regulation of the EMS system within the state as well as licensing local EMS agencies and personnel.

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<sup>i</sup> <https://www.nasemso.org/About/StateEMSAgencies/StateEMSAgencyListing.asp>

There is longstanding history of state regulation of EMS providers, with promulgation and execution of state laws and rules regarding EMS provider requirements for practice dating as far back as 1972. This includes accreditation of educational programs, use of a valid, reliable and legally defensible examination, criminal history checks, and ongoing competency maintenance requirements such as minimum continuing education credits and skill proficiency demonstration.

Additionally, recent developments in critical care transport and community paramedicine has served as a catalyst to the adoption of state laws and rules requiring physician oversight of EMS providers. These rules typically entail physician oversight and review of patient care, physician review of written patient care protocols, and when necessary, physician contact during patient care via radio or telephone.

### **State Medical Boards**

Today only four state medical boards have oversight of EMS professionals: Alaska State Medical Board; Hawaii Medical Board; Commonwealth of the Northern Mariana Islands; and the Montana Board of Medical Examiners. According NASEMSO, the licensing and regulation of EMS personnel began in the 1970's and has steadily migrated away from state boards of medicine to separate State EMS regulatory boards. These EMS boards are not only responsible for the licensing of EMS personnel, but also the nation's 21,000 EMS agencies that respond to 911 emergencies and provide transport, including specialty care air medical transport, and ground transport.<sup>ii</sup> This regulatory scheme is similar to the boards of pharmacy that license not only the individual pharmacists but also pharmacies, distributors, manufactures, and wholesalers.

The number of non-physician health care providers that are under the purview of state medical boards varies significantly throughout the country, from athletic trainers to polysomnography techs. The FSMB has not heretofore taken a position on what professions should be regulated by the medical board, with the exception of physician assistants for whom the medical and osteopathic boards license the majority, and therefore a specific recommendation and practice act for EMS personnel would not be in keeping with current policy or practice. Additionally, state medical boards would require extra human and financial resources to take on the licensure and regulation of another health occupation, and boards have not indicated their desire to do so. However, it should be noted that state medical boards have an indirect role in the oversight of EMS personnel through the licensure and regulation of the EMS associated physician medical directors.

### **Advisory Council of Board Executives**

The FSMB Advisory Council of Board Executives (Council) is made up of nine executive directors, including the two associate members of the FSMB Board of Directors and the

<sup>ii</sup> <https://www.nhtsa.gov/staticfiles/nti/ems/pdf/811723.pdf>

president and vice president of Administrators in Medicine. The Council provides guidance to the Board and FSMB staff on FSMB projects and services, state and federal legislative agenda, and is responsible for the three year review and revision of the *Essentials of a State Medical and Osteopathic Practice Act* and *Elements of a State Medical and Osteopathic Board*. The Board of Directors tasked the Council to evaluate Resolution 17-2 and make its recommendation to the Board. The Council met on August 17, 2017 at the FSMB office in Washington, D.C.

The Council noted the limited resources of state medical boards and the capacity of boards to take on additional regulated professions. The Council recognized the authority and discretion of the state to delegate oversight of the health occupation to best protect the public within their individual state structures. The Advisory Council recommended the Board of Directors not pursue policy in favor of Resolution 17-2, primarily due to the additional responsibilities and resources that would be required for the licensing of EMS providers, investigation and adjudication of complaints, and standard enforcement. Additionally, the Council noted current political pressures and criticisms of state occupational licensure generally and were concerned policy proposals for additional layers of oversight would be ill advised.

As an alternative approach to Resolution 17-2, the recommendations contained in FSMB's policy, *Regulatory Strategies for Achieving Greater Cooperation and Collaboration Among Health Professional Boards* (HOD 2017) may address the concerns expressed in Resolution 17-2. The policy recommends that state medical boards establish procedures for exchanging information with other boards, agencies, and departments responsible for regulating health-related occupations, facilities, and programs, and for coordinating investigations involving matters within the jurisdiction of more than one regulatory body. These procedures would apply to exchanging information between the state medical board and the state EMS agency to 1) conduct joint investigations; 2) share investigatory data; and create or develop processes to facilitate communication and collaboration between the board/agency.

Resolution 17-2 also speaks to the need for standardization of licensing and practice standards among the states. While there are variances in state licensure requirements for EMS personnel based on the needs and available resources in individual states, the majority require passage of a national examination and certification from the National Registry of Emergency Medical Technicians. Additionally, the NASEMSO, with support from the U.S. Department of Homeland Security, has initiated an interstate licensure compact that should further standardize licensing requirements among states. To participate in the compact, EMS personnel must have passed the National Registry of Emergency Medical Technicians (NREMT) examination for initial licensure and have an unrestricted license in his/her home state.

**Conclusion**

In conclusion, the Board of Directors concurs with the Advisory Council of Board Executives and does not recommend a policy change at this time regarding the licensure and regulation of EMS personnel. The Board further finds that the policy, *Regulatory Strategies for Achieving Greater Cooperation and Collaboration Among Health Professional Boards* (HOD 2017), applies and is a more feasible approach to Resolution 17-2.

**ITEM FOR ACTION:**

**For information.**



43 After extensive discussion and careful consideration, the concept of creating a new category of  
 44 Fellow was advanced which would allow for both appropriate recognition of the significant  
 45 contribution that executive directors provide to medical regulation as well as allow the  
 46 organization to more fully benefit from their expertise on our various committees, work groups  
 47 and task forces.

48  
 49 In September 2017, the Bylaws Committee met to develop a draft Bylaws proposal for the  
 50 Board’s consideration, as well as to consider other potential amendments to the Bylaws. At this  
 51 time, the Bylaws Committee determined that potential amendments designed to create a new  
 52 category of Fellow could be drafted within the structure of the Bylaws and were feasible to  
 53 consider. The Committee began to draft recommended revisions. In furtherance of this effort, the  
 54 Bylaws Committee also sought input from Administrators in Medicine (AIM). In December  
 55 2017, the Bylaws Committee distributed proposed revisions to the FSMB Member Medical  
 56 Boards for comment.

57  
 58 In January 2018, the Bylaws Committee discussed the feedback received from the Member  
 59 Medical Boards and AIM, all of which was favorable, and the draft proposal was then forwarded,  
 60 with no additional changes, to the Board of Directors for final review at its February 2018  
 61 meeting. On February 21, the Bylaws Committee discussed the Board’s feedback and finalized  
 62 its position on the proposal.

63  
 64 **Bylaws Proposal #1** can be found in its entirety behind **Attachment 1** and contains seven (7)  
 65 proposed amendments (#1-7) within **Article II. Classes of Membership, Election and**  
 66 **Membership Rights; Article III. Officers: Election and Duties; and Article IV. Board of**  
 67 **Directors.** The Bylaws Committee recommends the House of Delegates **ADOPT proposed**  
 68 **Amendments #1-7 as follows:**

69  
 70 **PROPOSED AMENDMENT #1**  
 71 Article II. Classes of Membership, Election and Membership Rights  
 72 Section B. Fellows

73  
 74 **There shall be two categories of Fellow of the FSMB:**

75  
 76 **1. Board Member Fellow. A Board Member Fellow is** ~~A~~an individual member who as a  
 77 result of appointment or confirmation is designated to be a member of a Member Medical  
 78 Board. **A Board Member Fellow** shall be a Fellow of the FSMB during the member’s period  
 79 of service on a Member Medical Board, and for a period of 36 months thereafter, **and**

80  
 81 **2. Staff Fellow. A Staff Fellow is an individual hired or appointed and who is**  
 82 **responsible for the day-to-day supervision and performance of the administrative duties**  
 83 **and functions for which a medical board is responsible. Each member board may**  
 84 **denote only one individual to serve as a Staff Fellow of the FSMB. No individual shall**

85 continue as a Staff Fellow upon termination of employment by or service to the  
86 Member Medical Board.

87

88 **PROPOSED AMENDMENT #2**

89 Article II. Classes of Membership, Election and Membership Rights

90 Section C. Honorary Fellows

91

92 ~~Thirty-six months after completion of service on a Member Medical Board, a A Board~~  
93 ~~Member Fellow as defined in section B, paragraph 1~~ shall become an Honorary Fellow of  
94 the FSMB thirty-six months after completion of service on a Member Medical Board. A  
95 Staff Fellow as defined in Section B, paragraph 2 shall become an Honorary Fellow of  
96 the FSMB upon termination of employment by or service to the Member Medical  
97 Board. An Honorary Fellow of the FSMB and may be appointed by the Chair to serve as a  
98 member of any committee or in any other appointive capacity.  
99

100 **PROPOSED AMENDMENT #3**

101 Article II. Classes of Membership, Election and Membership Rights

102 Section D. Associate Members

103

104 A Member Medical Board may designate one or more employees or staff members, other  
105 than an individual designated as a Staff Fellow, to be an Associate Member of the FSMB.  
106 No ~~Associate Member individual~~ shall continue ~~in that capacity~~ as an Associate Member  
107 upon termination of employment by or service to the Member Medical Board.  
108

109 **PROPOSED AMENDMENT #4**

110 Article III. Officers: Election and Duties

111 Section A. Officers of the FSMB

- 112
- 113 1. OFFICERS. The officers of the FSMB shall be that of Chair, Chair-elect, Treasurer and  
114 Secretary.
  - 115 2. Only an individual who is a Fellow as defined in Article II, Section B, Paragraph 1 at  
116 the time of the individual’s election or appointment shall be eligible for election or  
117 appointment as an Officer of the FSMB, except for the position of Secretary.
  - 118 3. The position of Secretary shall be an ex-officio office, without vote, and the President of  
119 the FSMB shall serve as Secretary.
- 120

121 **PROPOSED AMENDMENT #5**

122 Article IV. Board of Directors

123 Section A. Membership and Terms

- 124
- 125 1. MEMBERSHIP: The Board of Directors shall be composed of the Officers, the Immediate  
126 Past Chair, nine Directors-at-Large and two ~~Associate Members~~ Staff Fellows. At least

- 127 two members of the Board, who are not ~~Associate Members~~ Staff Fellows, shall be non-  
128 physicians, at least one of whom shall be a public/consumer member.
- 129 2. NOMINATION OF ~~ASSOCIATE MEMBERS~~ STAFF FELLOWS: Nominations for ~~Associate~~  
130 ~~Member~~ Staff Fellow positions shall be accepted from Member Boards, the Board of  
131 Directors and the Administrators in Medicine (~~AIM~~). ~~Associate Members~~ Staff Fellows  
132 shall be ~~elected~~ appointed by the Board of Directors in staggered terms in accordance  
133 with policies and procedures established by the Board of Directors.
- 134 3. TERMS: Directors-at-Large shall each serve for a term of three years and shall be eligible  
135 to be reelected to one additional term. Staff Fellows shall serve for a term of two years  
136 and shall be eligible to be reappointed to one additional term. A partial term totaling  
137 one-and-a-half years or more shall count as a full term. ~~Associate Members shall each~~  
138 ~~serve for a term of two years. Associate Members shall not be eligible to serve~~  
139 ~~consecutive terms.~~

140

#### 141 **PROPOSED AMENDMENT #6**

142 Article IV. Board of Directors

143 Section F. Vacancies

144

- 145 1. DIRECTORS-AT-LARGE: In the event of a vacancy in the membership of the Directors-at-  
146 Large, the Board of Directors may appoint a Fellow who meets the qualifications for the  
147 position to serve until the next Annual Meeting of the House of Delegates, at which time  
148 an individual shall be nominated and, if elected, shall serve for the remainder of the  
149 unexpired term. In the event a Director-at-Large is elected to the office of Treasurer or  
150 Chair-elect, that vacancy shall be filled by an election at the same Annual Meeting of the  
151 House of Delegates.
- 152 2. ~~ASSOCIATE MEMBERS~~ STAFF FELLOWS: In the event of a vacancy of ~~an Associate~~  
153 ~~Member~~ a Staff Fellow, the Board of Directors may appoint a substitute to complete the  
154 ~~Associate Member's~~ Staff Fellow's term in accordance with the policies established by  
155 the Board of Directors.

156

#### 157 **PROPOSED AMENDMENT #7**

158 Article IV. Board of Directors

159 Section G. Executive Committee of the Board

160

- 161 1. MEMBERSHIP: The Board of Directors shall establish an Executive Committee of the  
162 Board, which shall consist of the Chair as Chair, Chair-elect, Treasurer, Immediate Past  
163 Chair and ~~two~~ three Directors-at-Large. The Directors-at-Large shall be elected for a one-  
164 year term by majority vote of the Directors-at-Large and the ~~Associate Members of~~ Staff  
165 Fellows serving on the Board of Directors at the first regular meeting of the Board  
166 following the annual meeting of the House of Delegates. In the event of a vacancy in a  
167 Director-at-Large position, the Directors-at-Large and the ~~Associate Members of~~ Staff  
168 Fellows serving on the Board, by majority vote, shall choose another Director-at-Large to  
169 serve the remainder of the one-year term. A Staff Fellow may serve in one of the

170 **Director-at-Large positions. No more than one Staff Fellow may serve on the**  
171 **Executive Committee at any one time.** In the event of vacancy in the position of  
172 Immediate Past Chair, this position shall remain vacant until the next Annual Meeting of  
173 the House of Delegates.  
174

175 **BYLAWS PROPOSAL #2/ PROPOSED AMENDMENTS #8-23 (PROPOSED BY**  
176 **THE BYLAWS COMMITTEE)**

177  
178 **Bylaws Proposal #2** can be found in its entirety behind **Attachment 2** and contains sixteen (16)  
179 proposed amendments (#8-24) within **Article II. Classes of Membership, Election and**  
180 **Membership Rights; Article III. Officers: Election and Duties; Article IV. Board of**  
181 **Directors; Article V. Nomination by Petition for Board of Directors and Nominating**  
182 **Committee; and Article VII. Meetings.** For discussion purposes, these proposed amendments  
183 are divided into three sections.  
184

185 **1) Proposed Amendments #8-13** to **Articles III and IV** address the Bylaws Committee's  
186 recommendation that the Bylaws be changed so that the FSMB Immediate Past Chair is  
187 considered an Officer of the corporation given that when a Fellow is elected Chair-elect, the  
188 individual is expected to serve for three years: one year as Chair-elect; one year as Chair; and  
189 one year as Immediate Past Chair. The individual is also a standing member of the Executive  
190 Committee during those three years.  
191

192 Accordingly, the Bylaws Committee recommends the House of Delegates **ADOPT proposed**  
193 **Amendments #8-13 as follows:**  
194

195 **PROPOSED AMENDMENT #8**

196 Article III. Officers: Election and Duties

197 Section A. Officers of the FSMB

- 198  
199 1. OFFICERS. The officers of the FSMB shall be that of Chair, Chair-elect, **Immediate Past**  
200 **Chair,** Treasurer and Secretary.  
201

202 **PROPOSED AMENDMENT #9**

203 Article III. Officers: Election and Duties

204 Section B. Election of Officers

- 205  
206 1. The Chair-elect shall ascend to the position of Chair at the Annual Meeting following the  
207 meeting in which the Chair-elect was elected.  
208 2. The Chair-elect shall be elected at each Annual Meeting of the House of Delegates.  
209 **3. The Immediate Past Chair assumes that position upon the Chair-elect ascending to**  
210 **the position of Chair.**

- 211 **34.** The Treasurer shall be elected every third year at the Annual Meeting of the House of  
212 Delegates.  
213 **45.** Officers shall be elected by a majority of the members of the House of Delegates present  
214 and voting.  
215 **56.** In any election, should no candidate receive a majority of the votes cast, a runoff election  
216 shall be held between the two candidates who receive the most votes for that office on the  
217 first ballot. Up to two additional runoff elections shall be held.  
218 **67.** Prior to each election, the presiding officer shall cast a sealed vote that shall be counted  
219 only to resolve a tie that cannot be decided by the process set forth in this section.  
220

221 **PROPOSED AMENDMENT #10**

222 Article III. Officers: Election and Duties

223 Section C. Duties of Officers

224  
225 **3. The duties of the Immediate Past Chair shall be as follows:**

226 **a. Assist the Chair in the transition from Chair-elect to Chair;**

227 **b. Serve as chair of the Nominating Committee; and**

228 **c. Perform such other duties and responsibilities as the Chair shall determine.**

229 **34.** The duties of the Treasurer shall be as follows:

230 a. Perform the duties customary to that office;

231 b. Perform such other duties as the Bylaws and custom and parliamentary usage may  
232 require or as the Board of Directors shall deem appropriate;

233 c. Serve as an ex officio member of the Audit Committee; and

234 d. Serve as chair of the Finance Committee.

235 **45.** The duties of the Secretary shall be as follows:

236 a. Administer the affairs of the FSMB; and

237 b. Such duties and responsibilities as the FSMB and the Board of Directors shall  
238 determine.  
239

240 **PROPOSED AMENDMENT #11**

241 Article III. Officers: Election and Duties

242 Section D. Terms of Office and Succession

243  
244 1. The Chair and Chair-elect shall serve for single terms of one year or until their successors  
245 assume office.

246 **2. The Immediate Past Chair shall serve until a successor to the current Chair assumes**  
247 **office.**

248 **23.** The Treasurer shall serve for a single term of three years or until the Treasurer's  
249 successor assumes the office.

250 **34.** Officers shall assume office upon final adjournment of the Annual Meeting of the House  
251 of Delegates at which they were elected.

252 **45.** The term of the Secretary is co-terminus with that of the President.  
253

254 **PROPOSED AMENDMENT #12**

255 Article III. Officers: Election and Duties

256 Section E. Vacancies

257

258 **3. In the event of a vacancy in the office of Immediate Past Chair, the office shall**  
259 **remain open until a new Chair assumes the office.**

260 **34.** In the event of a vacancy in the office of the Treasurer, the Board of Directors shall elect  
261 one of the Directors-at-Large to serve as Treasurer, with one vote on the Board of  
262 Directors and one vote on the Executive Committee, until the next year’s Annual Meeting  
263 of the House of Delegates, at which time a Treasurer shall be elected.  
264

265 **PROPOSED AMENDMENT #13**

266 Article IV. Board of Directors

267 Section A. Membership and Terms

268

269 1. MEMBERSHIP: The Board of Directors shall be composed of the Officers, ~~the Immediate~~  
270 ~~Past Chair~~, nine Directors-at-Large and two Associate Members. At least two members  
271 of the Board, who are not Associate Members, shall be non-physicians, at least one of  
272 whom shall be a public/consumer member.  
273

274 **2) Proposed Amendment #14** to **Article IV** addresses the Bylaws Committee’s  
275 recommendation that the Bylaws be changed to offer greater clarity about the process for  
276 removing an individual from the Board of Directors. Accordingly, the Bylaws Committee  
277 recommends the House of Delegates **ADOPT proposed Amendment #14 as follows:**  
278

279 **PROPOSED AMENDMENT #14**

280 Article IV. Board of Directors

281 Section E. Removal from Office

282

283 1. REMOVAL: Any officer or member of the Board of Directors may be removed for any  
284 cause deemed sufficient by an affirmative vote of two-thirds of the total members of the  
285 Board of Directors entitled to vote and who are not subject to removal from office.

286 2. PROCEDURE: The procedure for removal shall be as follows:

287 a. The Board shall file with the Secretary of the Board and deliver a written statement of  
288 the cause for removal to the officer or board member in sufficient detail as to state the  
289 grounds for the removal. Delivery to the officer or **board** member shall be by certified  
290 mail, return receipt requested, to the last address known to the Board ~~and is effective~~  
291 ~~upon mailing.~~

292 b. The officer or board member shall deliver a sworn written response to the Board, no  
293 later than thirty calendar days after the written statement **of the cause for removal** is  
294 ~~filed with the Secretary of the Board~~ **delivered to the officer or board member in**  
295 **question.** Delivery to the Board shall be by certified mail, return receipt requested,

296 directed to the Secretary of the Board at the FSMB corporate office. ~~Delivery is~~  
297 ~~effective upon mailing.~~

298 c. At the ~~next~~ Board meeting following the date the response is due, the Board shall  
299 determine whether or not to proceed with removal. Notice of the Board’s action shall  
300 be delivered to the officer or ~~B~~board member by certified mail, return receipt  
301 requested. If the officer or board member ~~did~~ does not file a written response the  
302 Board shall proceed with a determination. ~~Delivery is effective upon mailing.~~

303 d. If the Board votes to proceed with removal of the officer or ~~B~~board member, at a  
304 Board meeting ~~held no less than thirty days after delivery of the notice~~, the ~~B~~board  
305 member shall be afforded the opportunity to address the Board on the merits of the  
306 allegations and produce any relevant information to the Board after which the Board  
307 shall make a determination. The Board meeting at which the officer or board  
308 member has the opportunity to address the Board shall be held no less than  
309 thirty days after delivery of the notice of removal.

310 3. APPEAL: Any officer or member of the Board of Directors removed by the Board of  
311 Directors may appeal to the House of Delegates at its next business meeting. The officer  
312 or member may be reinstated by a two-thirds vote of the House of Delegates.

313 4. DELIVERY: For the purposes of this section, “Delivery” is effective upon mailing.

314  
315 **3) Proposed Amendments #15-24** to Articles II, IV, V and VII address the Bylaws  
316 Committee’s recommendation that the Bylaws be changed to reflect an increase in the Executive  
317 Committee from two to three Directors-at-Large, minor editorial improvements. Accordingly,  
318 the Bylaws Committee recommends the House of Delegates **ADOPT proposed Amendments**  
319 **#15-24 as follows:**

320  
321 **PROPOSED AMENDMENT #15**  
322 Article II. Classes of Membership, Election and Membership Rights  
323 Section B. Fellows  
324  
325 An individual member who as a result of appointment or confirmation is designated to be a  
326 member of a Member Medical Board shall be a Fellow of the FSMB during the member’s  
327 period of service on a Member Medical Board, and for a period of ~~36~~ thirty-six months  
328 thereafter.

329  
330 **PROPOSED AMENDMENT #16**  
331 Article IV. Board of Directors  
332 Section B. Nominations  
333  
334 2. The Nominating Committee shall mail its roster of candidates to Member Boards not  
335 fewer than ~~60~~ sixty days prior to the Annual Meeting of the House of Delegates.

336  
337

338 **PROPOSED AMENDMENT #17**

339 Article IV. Board of Directors

340 Section D. Duties of the Board of Directors

341

342 2. The Board of Directors shall carry out the mandates of the FSMB as established by the  
343 House of Delegates, and it shall have full and complete ~~power and~~ authority to perform  
344 all acts and to transact all business for and on behalf of the FSMB.

345

346 **PROPOSED AMENDMENT #18**

347 Article IV. Board of Directors

348 Section F. Vacancies

349

350 1. DIRECTORS-AT-LARGE: In the event of a vacancy in the membership of the Directors-at-  
351 Large, the Board of Directors may appoint a Fellow who meets the qualifications for the  
352 position to serve until the next Annual Meeting of the House of Delegates, at which time  
353 ~~an individual~~ a Fellow shall be ~~nominated and, if~~ elected, and shall serve ~~for~~ the  
354 remainder of the unexpired term. In the event a Director-at-Large is elected to the office  
355 of Treasurer or Chair-elect, that vacancy shall be filled by an election at the same Annual  
356 Meeting of the House of Delegates.

357

358 **PROPOSED AMENDMENT #19**

359 Article IV. Board of Directors

360 Section G. Executive Committee of the Board

361

362 1. MEMBERSHIP: The Board of Directors shall establish an Executive Committee of the  
363 Board, which shall consist of the Chair as Chair, Chair-elect, Treasurer, Immediate Past  
364 Chair and ~~two~~ three Directors-at-Large. The Directors-at-Large shall be elected for a  
365 one-year term by majority vote of the Directors-at-Large and the Associate Members of  
366 the Board of Directors at the first regular meeting of the Board following the Annual  
367 Meeting of the House of Delegates. In the event of a vacancy in a Director-at-Large  
368 position, the Directors-at-Large and the Associate Members of the Board, by majority  
369 vote, shall choose another Director-at-Large to serve the remainder of the one-year term.  
370 In the event of vacancy in the position of Immediate Past Chair, this position shall remain  
371 vacant until the next Annual Meeting of the House of Delegates.

372

373 **PROPOSED AMENDMENT #20**

374 Article V. Nomination by Petition for Board of Directors and Nominating Committee

375 Section A. Submission of a Petition

376

377 3. The deadline to submit petitions to the Administrative Staff is ~~21~~ twenty-one days prior  
378 to the Annual Meeting.

379

380

381 **PROPOSED AMENDMENT #21**

382 Article V. Nomination by Petition for Board of Directors and Nominating Committee

383 Section B. Validation and Placement on Ballot

384

385 3. The names of those seeking to run by petition whose petitions are deemed valid shall be  
386 distributed to the Voting Delegates not fewer than ~~14~~ **fourteen** days prior to the Annual  
387 Meeting.

388

389 **PROPOSED AMENDMENT #22**

390 Article VII. Meetings

391 Section A. Annual Meeting of the House of Delegates

392

393 The annual meeting of the House of Delegates of the FSMB, which shall be called the House  
394 of Delegates, shall be held at such time and place as may be fixed by the Board of Directors.  
395 Written notice of the time and place of the meeting shall be given to all Member Medical  
396 Boards by mail not fewer than ~~90~~ **ninety** days prior to the date of the meeting. **Notice is**  
397 **effective upon mailing.**

398

399 **PROPOSED AMENDMENT #23**

400 Article VII. Meetings

401 Section B. Special Meetings of the House of Delegates

402

403 Special meetings of the House of Delegates may be called at any time by the Chair, on the  
404 written request of ten Member Medical Boards or by action of the Board of Directors.  
405 Written notice of the time and place of such meetings shall be given to all Member Medical  
406 Boards by mail not fewer than ~~30~~ **thirty** days prior to the date of the meeting. **Notice is**  
407 **effective upon mailing.**

408

409 **PROPOSED AMENDMENT #24**

410 Article XIV. Adoption and Amendment of Bylaws, Effective Date

411 Section A. Amendment

412

413 These Bylaws may be amended at any annual meeting of the House of Delegates by two-  
414 thirds of those present and voting. Bylaws changes may be proposed only by the Board of  
415 Directors, Member Medical Boards or the Bylaws Committee **and its members**. All such  
416 proposals must be submitted in writing to the Bylaws Committee, in care of the Secretary of  
417 the FSMB. The Bylaws Committee shall inform the Member Medical Boards of its meeting  
418 dates not fewer than ~~60~~ **sixty** days in advance of the meeting. The recommendations of the  
419 Bylaws Committee and the full texts of all proposed amendments recommended to the  
420 Committee shall be sent to each Member Medical Board not fewer than ~~60~~ **sixty** days prior to  
421 the Annual Meeting of the House of Delegates at which they are to be considered.

422

423 **BYLAWS PROPOSAL #3/ PROPOSED AMENDMENT #25 (PROPOSED BY THE**  
424 **BYLAWS COMMITTEE)**

425  
426 **Bylaws Proposal #3** can be found in its entirety behind **Attachment 3** and contains one (1)  
427 proposed amendment (#25) within **Article VIII. Standing and Special Committees.**

428  
429 The Bylaws Committee proposes that **Article VIII** be changed to allow the FSMB Chair an  
430 opportunity to appoint an Associate Member to the Editorial Committee should the Chair so  
431 choose. Accordingly, the Bylaws Committee recommends the House of Delegates **ADOPT**  
432 **proposed Amendment #25 as follows:**

433  
434 **PROPOSED AMENDMENT #25**

435 Article VIII. Standing and Special Committees

436 Section D. Editorial Committee

437

- 438 1. An Editorial Committee, not to exceed twelve Fellows and three ~~non-member subject~~  
439 ~~matter experts~~ **non-Fellows, at least two of whom shall be subject matter experts,**  
440 shall advise the Editor-in-Chief on editorial policy for the FSMB's official publication,  
441 and shall serve as the editorial board of that publication and otherwise assist the Editor-  
442 in-Chief in the performance of duties as appropriate and necessary. No officer or member  
443 of the Board of Directors shall serve on this Committee.

444

445 **BYLAWS PROPOSAL #4/ PROPOSED AMENDMENT #26 (PROPOSED BY THE**  
446 **TENNESSEE BOARD OF MEDICAL EXAMINERS)**

447

448 **Bylaws Proposal #4** can be found in its entirety behind **Attachment 4** and contains one (1)  
449 proposed amendment (#26) within **Article IV. Board of Directors.**

450

451 The Tennessee Board of Medical Examiners proposes that **Article IV** be changed to allow the  
452 inclusion of two (2) public/consumer members, who are not Associate Members, to serve on the  
453 Board of Directors as follows:

454

455 **PROPOSED AMENDMENT #26**

456 Article IV. Board of Directors

457 Section A. Membership and Terms

458

- 459 1. MEMBERSHIP: The Board of Directors shall be composed of the Officers, the  
460 Immediate Past Chair, nine Directors-at-Large and two Associate Members. At least two  
461 members of the Board, who are not Associate Members, shall be ~~non-physicians, at~~  
462 ~~least one of whom shall be a~~ public/consumer members.

463

464 The Tennessee Board suggests that this modification to the Bylaws makes clear that the  
465 public/consumer members' participation and perspective on the Board is valued and aligned with

466 the Member Medical Boards of the FSMB, and notes that non-physician members can still be  
467 elected to the Board if they are Fellows of the FSMB.

468  
469 The Bylaws Committee considered the Tennessee Board's position and discussed the current  
470 process for electing Fellows to the Board of Directors, which begins with the election of the  
471 requisite number of non-physicians and public/consumer members and a ballot that only includes  
472 the non-physician and public/consumer member candidates. After those positions are filled, any  
473 non-physician or public/consumer member candidate not elected at that time is included on the  
474 next ballot with the physician candidates.

475  
476 The Bylaws Committee opined that while it is true that the Tennessee Board's proposed change  
477 to the Bylaws would still provide an opportunity for non-physicians (who are not  
478 public/consumer members because of their nexus to healthcare) to be elected to the Board, they  
479 would not have the added benefit of being considered independently of physicians, which might  
480 discourage a non-physician, such as a physician assistant, from running for election because of a  
481 perception that voting delegates would likely favor the physicians.

482  
483 Given the importance of this issue, the Bylaws Committee agreed that additional discussion is  
484 needed to consider all of the possible ramifications of this proposed change as well as how it  
485 might affect the rest of the Bylaws. The Committee also concurred that because of the  
486 significance of the changes being presented to the House of Delegates in Proposal 1, it would be  
487 best to act on Proposal 4 in 2019. Therefore, the Bylaws Committee recommends the House of  
488 Delegates **TABLE proposed Amendment #26 until the Bylaws Committee can make its final**  
489 **recommendation to the House in 2019.**

490  
491  
492

# **Attachment 1**

1 **2018 FSMB BYLAWS**  
2 **PROPOSED AMENDMENTS**  
3 **PROPOSAL #1**

4 (to enhance role of state medical board executive directors in FSMB governance)  
5

6 **ARTICLE I. NAME**

7 The corporation shall be known as the Federation of State Medical Boards of the United States,  
8 Inc. ("FSMB").

9 **ARTICLE II. CLASSES OF MEMBERSHIP, ELECTION AND MEMBERSHIP RIGHTS**

10 **SECTION A. MEMBER MEDICAL BOARDS**

11 The term "Member Medical Board" as used in the Articles of Incorporation and in these Bylaws  
12 shall refer to any board, committee or other group in any state, territory, the District of Columbia  
13 or possession of the United States of America that is empowered by law to pass on the  
14 qualifications of applicants for licensure to practice allopathic or osteopathic medicine or to  
15 discipline such licensees. If a state or other jurisdiction has more than one such entity and if each  
16 is an independent agency unrelated to the others, each is eligible for membership. Any eligible  
17 Medical Board may become a Member Medical Board upon approval of its application by the  
18 Board of Directors.

19 **SECTION B. FELLOWS**

20 **There shall be two categories of Fellow of the FSMB:**

21 **1. Board Member Fellow. A Board Member Fellow is** ~~A~~an individual member who as a result  
22 of appointment or confirmation is designated to be a member of a Member Medical Board. **A**  
23 **Board Member Fellow** shall be a Fellow of the FSMB during the member's period of service on  
24 a Member Medical Board, and for a period of 36 months thereafter, **and**

25 **2. Staff Fellow. A Staff Fellow is an individual hired or appointed and who is responsible**  
26 **for the day-to-day supervision and performance of the administrative duties and functions**  
27 **for which a medical board is responsible. Each member board may denote only one**  
28 **individual to serve as a Staff Fellow of the FSMB. No individual shall continue as a Staff**  
29 **Fellow upon termination of employment by or service to the Member Medical Board.**

31 **SECTION C. HONORARY FELLOWS**

32 ~~Thirty-six months after completion of service on a Member Medical Board, a A Board~~  
 33 ~~Member Fellow as defined in section B, paragraph 1~~ shall become an Honorary Fellow of the  
 34 FSMB ~~thirty-six months after completion of service on a Member Medical Board. A Staff~~  
 35 ~~Fellow as defined in Section B, paragraph 2 shall become an Honorary Fellow of the FSMB~~  
 36 ~~upon termination of employment by or service to the Member Medical Board. An Honorary~~  
 37 ~~Fellow of the FSMB and~~ may be appointed by the Chair to serve as a member of any committee  
 38 or in any other appointive capacity.

39 **SECTION D. ASSOCIATE MEMBERS**

40 A Member Medical Board may designate one or more employees or staff members, other than  
 41 an individual designated as a Staff Fellow, to be an Associate Member of the FSMB. No  
 42 ~~Associate Member~~ individual shall continue ~~in that capacity~~ as an Associate Member upon  
 43 termination of employment by or service to the Member Medical Board.

44 **SECTION E. COURTESY MEMBERS**

45 Any physician or physician assistant licensed by a Member Medical Board or an Affiliate Member  
 46 Board and not eligible for any other type of membership may become a Courtesy Member of the  
 47 FSMB upon approval of the candidate's application. A Courtesy Member may serve as a member  
 48 of a committee and in any other capacity upon appointment by the Chair.

49 **SECTION F. AFFILIATE MEMBERS BOARDS**

50 A board or authority that is not otherwise eligible for membership may become an Affiliate Member  
 51 Board of the FSMB upon approval of its application by the Board of Directors if the board or  
 52 authority licenses either:

- 53 1. Allopathic or osteopathic physicians or physician assistants in the United States; or
- 54 2. Allopathic or osteopathic physicians if the board or authority is located in another country.

55 **SECTION G. OFFICIAL OBSERVERS**

56 An organization may apply for Official Observer status at meetings of the House of Delegates.  
 57 The Board of Directors shall prescribe rules and procedures to govern the application for, the  
 58 granting of and the exercise of Official Observer status.

59 **SECTION H. RIGHTS OF MEMBERS**

60 Except as otherwise provided in these Bylaws, rights, duties, privileges and obligations of a  
61 member of the FSMB may be exercised only by a Member Medical Board.

62 **SECTION I. METHODS OF NOMINATION TO ELECTED OFFICE**

63 Nomination by the Nominating Committee or Nomination by Petition pursuant to Articles III, IV, V  
64 and VIII shall be the sole methods of nomination to an elected office of the FSMB. A candidate  
65 who runs for and is not elected to an elected office shall be ineligible to be nominated for any other  
66 elected office during the same election cycle.

67 **ARTICLE III. OFFICERS: ELECTION AND DUTIES**

68 **SECTION A. OFFICERS OF THE FSMB**

- 69 1. OFFICERS. The officers of the FSMB shall be that of Chair, Chair-elect, Treasurer and  
70 Secretary.
- 71 2. Only an individual who is a Fellow as defined in Article II, Section B, Paragraph 1 at the  
72 time of the individual's election or appointment shall be eligible for election or appointment as  
73 an Officer of the FSMB, except for the position of Secretary.
- 74 3. The position of Secretary shall be an ex-officio office, without vote, and the President of the  
75 FSMB shall serve as Secretary.

76 **SECTION B. ELECTION OF OFFICERS**

- 77 1. The Chair-elect shall ascend to the position of Chair at the Annual Meeting following the  
78 meeting in which the Chair-elect was elected.
- 79 2. The Chair-elect shall be elected at each Annual Meeting of the House of Delegates.
- 80 3. The Treasurer shall be elected every third year at the Annual Meeting of the House of  
81 Delegates.
- 82 4. Officers shall be elected by a majority of the members of the House of Delegates present and  
83 voting.
- 84 5. In any election, should no candidate receive a majority of the votes cast, a runoff election shall  
85 be held between the two candidates who receive the most votes for that office on the first  
86 ballot. Up to two additional runoff elections shall be held.

87 6. Prior to each election, the presiding officer shall cast a sealed vote that shall be counted only  
 88 to resolve a tie that cannot be decided by the process set forth in this section.

89 **SECTION C. DUTIES OF OFFICERS**

90 1. The duties of the Chair shall be as follows:

- 91 a. Preside at all meetings and sessions of the House of Delegates and the Board of Directors;
- 92 b. Perform the duties customary to the office of the Chair;
- 93 c. Make appointments to committees and define duties of committee members in accordance  
 94 with these Bylaws, except as otherwise provided herein;
- 95 d. Serve, ex officio, on all committees except as otherwise provided herein; and
- 96 e. Exercise such other rights and customs as the Bylaws and parliamentary usage may  
 97 require or as the FSMB or the Board of Directors shall deem appropriate.

98 2. The duties of the Chair-elect shall be as follows:

- 99 a. Assist the Chair in the discharge of the Chair’s duties; and
- 100 b. Perform the duties of the Chair at the Chair’s request or, in the event of the Chair’s  
 101 temporary absence or incapacitation, at the request of the Board of Directors.

102 3. The duties of the Treasurer shall be as follows:

- 103 a. Perform the duties customary to that office;
- 104 b. Perform such other duties as the Bylaws and custom and parliamentary usage may require  
 105 or as the Board of Directors shall deem appropriate;
- 106 c. Serve as an ex officio member of the Audit Committee; and
- 107 d. Serve as chair of the Finance Committee.

108 4. The duties of the Secretary shall be as follows:

- 109 a. Administer the affairs of the FSMB; and
- 110 b. Such duties and responsibilities as the FSMB and the Board of Directors shall determine.

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114 **SECTION D. TERMS OF OFFICE AND SUCCESSION**

- 115 1. The Chair and Chair-elect shall serve for single terms of one year or until their successors
- 116 assume office.
- 117 2. The Treasurer shall serve for a single term of three years or until the Treasurer’s successor
- 118 assumes the office.
- 119 3. Officers shall assume office upon final adjournment of the Annual Meeting of the House of
- 120 Delegates at which they were elected.
- 121 4. The term of the Secretary is co-terminus with that of the President.

122 **SECTION E. VACANCIES**

- 123 1. In the event of a vacancy in the office of the Chair, the Chair-elect shall assume the position of
- 124 Chair for the remainder of the unexpired term, and shall then serve a full one-year term as
- 125 Chair.
- 126 2. In the event of a vacancy in the office of the Chair-elect, the Board of Directors shall appoint a
- 127 Director-at-Large to assume the duties, but not the office, of Chair-elect for the remainder of
- 128 the unexpired term. At the next Annual Meeting of the House of Delegates, both a Chair and a
- 129 Chair-elect shall be elected in accordance with the provisions in Section B of this Article.
- 130 3. In the event of a vacancy in the office of the Treasurer, the Board of Directors shall elect one
- 131 of the Directors-at-Large to serve as Treasurer, with one vote on the Board of Directors and
- 132 one vote on the Executive Committee, until the next year’s Annual Meeting of the House of
- 133 Delegates, at which time a Treasurer shall be elected.

134 **ARTICLE IV. BOARD OF DIRECTORS**

135 **SECTION A. MEMBERSHIP AND TERMS**

- 136 1. MEMBERSHIP: The Board of Directors shall be composed of the Officers, the Immediate Past
- 137 Chair, nine Directors-at-Large and two ~~Associate Members~~ Staff Fellows. At least two
- 138 members of the Board, who are not ~~Associate Members~~ Staff Fellows, shall be non-
- 139 physicians, at least one of whom shall be a public/consumer member.
- 140 2. NOMINATION OF ~~ASSOCIATE MEMBERS~~ STAFF FELLOWS: Nominations for ~~Associate Member~~
- 141 Staff Fellow positions shall be accepted from Member Boards, the Board of Directors and the
- 142 Administrators in Medicine (~~AIM~~). ~~Associate Members~~ Staff Fellows shall be elected

143 **appointed** by the Board of Directors in staggered terms in accordance with policies and  
 144 procedures established by the Board of Directors.

145 3. TERMS: Directors-at-Large shall each serve for a term of three years and shall be eligible to be  
 146 reelected to one additional term. **Staff Fellows shall serve for a term of two years and shall**  
 147 **be eligible to be reappointed to one additional term.** A partial term totaling one-and-a-half  
 148 years or more shall count as a full term. ~~Associate Members shall each serve for a term of~~  
 149 ~~two years. Associate Members shall not be eligible to serve consecutive terms.~~

## 150 SECTION B. NOMINATIONS

151 1. The Nominating Committee shall submit a roster of one or more candidates for each of the  
 152 offices and positions to be filled by election at the Annual Meeting of the House of Delegates.  
 153 2. The Nominating Committee shall mail its roster of candidates to Member Boards not fewer  
 154 than 60 days prior to the Annual Meeting of the House of Delegates.

## 155 SECTION C. ELECTION OF DIRECTORS-AT-LARGE

156 1. At least three of the Directors-at-Large shall be elected each year at the Annual Meeting of the  
 157 House of Delegates by a majority of the votes cast.  
 158 2. If no candidate receives a majority of the votes on the first ballot, and one seat is to be filled, a  
 159 runoff election shall be held between the two candidates who received the most votes on the  
 160 first ballot.  
 161 3. If more than one seat is to be filled from a single list of candidates, and if one or more seats  
 162 are not filled by majority vote on the first ballot, a runoff election shall be held, with the ballot  
 163 listing candidates equal in number to twice the number of seats remaining to be filled. These  
 164 candidates shall be those remaining who received the most votes on the first ballot. The same  
 165 procedure shall be used for any required subsequent runoff elections. In the event of a tie vote  
 166 in a runoff election up to two additional runoff elections shall be held.  
 167 4. Prior to the election, the presiding officer shall cast a sealed vote, ranking each candidate in a  
 168 list. The presiding officer's vote is counted for the candidate in the runoff election who is highest  
 169 on the list. The presiding officer's vote is counted only to resolve a tie that cannot be decided  
 170 by the process set forth in this section.  
 171 5. Directors shall assume office upon final adjournment of the Annual Meeting of the House of  
 172 Delegates at which they were elected.

173 6. Only an individual who is a Fellow at the time of the individual's election shall be eligible for  
 174 election as a Director of the FSMB.

175 **SECTION D. DUTIES OF THE BOARD OF DIRECTORS**

176 1. The control and administration of the FSMB is vested in the Board of Directors and it shall act  
 177 for the FSMB between Annual Meetings.

178 2. The Board of Directors shall carry out the mandates of the FSMB as established by the House  
 179 of Delegates, and it shall have full and complete power and authority to perform all acts and to  
 180 transact all business for and on behalf of the FSMB.

181 3. The Board of Directors shall conduct and manage all property, affairs, work and activities of  
 182 the FSMB, subject only to the provisions of the Articles of Incorporation and these Bylaws and  
 183 to resolutions and enactments of the House of Delegates.

184 4. The Board of Directors shall be the fiscal agent of the FSMB.

185 5. The Board of Directors shall establish rules for its operations and meetings.

186 6. The FSMB shall indemnify Directors, Officers and other individuals acting on behalf of the  
 187 FSMB if such indemnification is in accordance with the laws of the State of Nebraska and the  
 188 operational policies and procedures of the Board of Directors, as adopted. The Board shall  
 189 report to the membership of the FSMB at the Annual Meeting of the House of Delegates.

190 7. The Board of Directors shall establish a strategic plan for the FSMB that states the FSMB  
 191 mission and objectives and shall submit that plan to the House of Delegates for ratification,  
 192 modification or rejection. The Board shall review the current strategic plan annually and  
 193 propose any amendments to the Annual Meeting of the House of Delegates for ratification,  
 194 modification or rejection. The President shall report to the Annual Meeting of the House of  
 195 Delegates on the extent to which the FSMB's stated objectives have been accomplished in the  
 196 preceding year.

197 **SECTION E. REMOVAL FROM OFFICE**

198 1. REMOVAL: Any officer or member of the Board of Directors may be removed for any cause  
 199 deemed sufficient by an affirmative vote of two-thirds of the total members of the Board of  
 200 Directors entitled to vote and who are not subject to removal from office.

201 2. PROCEDURE: The procedure for removal shall be as follows:

- 202 a. The Board shall file with the Secretary of the Board and deliver a written statement of the  
203 cause for removal to the officer or board member in sufficient detail as to state the grounds  
204 for the removal. Delivery to the officer or member shall be by certified mail, return receipt  
205 requested, to the last address known to the Board and is effective upon mailing.
  - 206 b. The officer or board member shall deliver a sworn written response to the Board no later  
207 than thirty calendar days after the written statement is filed with the Secretary of the Board.  
208 Delivery to the Board shall be by certified mail, return receipt requested, directed to the  
209 Secretary of the Board at the FSMB corporate office. Delivery is effective upon mailing.
  - 210 c. At the next Board meeting, the Board shall determine whether or not to proceed with  
211 removal. Notice of the Board’s action shall be delivered to the officer or Board member by  
212 certified mail, return receipt requested. If the officer or board member did not file a written  
213 response the Board shall proceed with a determination. Delivery is effective upon mailing.
  - 214 d. If the Board votes to proceed with removal of the officer or Board member, at a Board  
215 meeting held no less than thirty days after delivery of the notice, the Board member shall  
216 be afforded the opportunity to address the Board on the merits of the allegations and  
217 produce any relevant information to the Board after which the Board shall make a  
218 determination.
- 219 3. APPEAL: Any officer or member of the Board of Directors removed by the Board of Directors  
220 may appeal to the House of Delegates at its next business meeting. The officer or member  
221 may be reinstated by a two-thirds vote of the House of Delegates.

222 **SECTION F. VACANCIES**

- 223 1. DIRECTORS-AT-LARGE: In the event of a vacancy in the membership of the Directors-at-Large,  
224 the Board of Directors may appoint a Fellow who meets the qualifications for the position to  
225 serve until the next Annual Meeting of the House of Delegates, at which time an individual shall  
226 be nominated and, if elected, shall serve for the remainder of the unexpired term. In the event  
227 a Director-at-Large is elected to the office of Treasurer or Chair-elect, that vacancy shall be  
228 filled by an election at the same Annual Meeting of the House of Delegates.
- 229 2. ~~ASSOCIATE MEMBERS~~ **STAFF FELLOWS**: In the event of a vacancy of ~~an Associate Member a~~  
230 **Staff Fellow**, the Board of Directors may appoint a substitute to complete the **Associate**  
231 **Member’s Staff Fellow’s** term in accordance with the policies established by the Board of  
232 Directors.

233 **SECTION G. EXECUTIVE COMMITTEE OF THE BOARD**

- 234 1. MEMBERSHIP: The Board of Directors shall establish an Executive Committee of the Board,  
 235 which shall consist of the Chair as Chair, Chair-elect, Treasurer, Immediate Past Chair and  
 236 ~~two~~ three Directors-at-Large. The Directors-at-Large shall be elected for a one-year term by  
 237 majority vote of the Directors-at-Large and the ~~Associate Members of~~ Staff Fellows serving  
 238 on the Board of Directors at the first regular meeting of the Board following the annual meeting  
 239 of the House of Delegates. In the event of a vacancy in a Director-at-large position, the  
 240 Directors-at-Large and the ~~Associate Members of~~ Staff Fellows serving on the Board, by  
 241 majority vote, shall choose another Director-at-Large to serve the remainder of the one-year  
 242 term. A Staff Fellow may serve in one of the Director-at-Large positions. No more than  
 243 one Staff Fellow may serve on the Executive Committee at any one time. In the event of  
 244 vacancy in the position of Immediate Past Chair, this position shall remain vacant until the next  
 245 Annual Meeting of the House of Delegates.
- 246 2. DUTIES: In intervals between Board meetings, the Executive Committee shall act for and on  
 247 behalf of the Board in any matters that require prompt attention. It shall not modify actions  
 248 previously taken by the Board unless additional information or a change of circumstances is  
 249 presented and warrants additional action.
- 250 3. MEETINGS: The Executive Committee may meet as often as it deems necessary or appropriate,  
 251 either in person, telephonically, electronically or by unanimous written consent, and at such  
 252 times and places and manner as the Chair may determine. Minutes must be kept of all  
 253 meetings.
- 254 4. REPORTING: The Executive Committee shall report in writing all formal actions taken by it to the  
 255 Board of Directors within five working days of taking those actions. At each meeting of the  
 256 Board, the Executive Committee shall present to the Board a written report of all its formal  
 257 actions since the previous meeting of the Board.

258 **SECTION H. PUBLIC POLICY STATEMENTS**

259 A “public policy” is defined as the official public position of the FSMB on a matter that may be  
 260 reasonably expected to affect Member Boards when dealing with their licensees, other health care  
 261 providers, health-related special interest groups, governmental bodies or the public. The House  
 262 of Delegates is the official public policy-making body of the FSMB. When the interests of the FSMB  
 263 require more immediate action, the Board of Directors, or the President in consultation with the

264 Chair, if feasible, is authorized to issue statements on matters of public policy between Annual  
265 Meetings.

266 **ARTICLE V. NOMINATION BY PETITION FOR BOARD OF DIRECTORS AND NOMINATING**  
267 **COMMITTEE**

268 **SECTION A. SUBMISSION OF A PETITION**

269 1. At the time the Nominating Committee’s roster of candidates is distributed to the Member  
270 Boards, the Boards will be informed that a Fellow who is qualified for nomination, but not  
271 otherwise nominated by the Nominating Committee, may seek to run for a position on the  
272 Board of Directors as an Officer or Director-at-Large, or for a position on the Nominating  
273 Committee.

274 2. In order to be placed on the ballot, the Fellow seeking nomination is required to present a  
275 petition to Administrative Staff that is signed by at least one Fellow from at least four Member  
276 Boards as well as a fellow from the Board of the member seeking nomination.

277 3. The deadline to submit petitions to the Administrative Staff is 21 days prior to the Annual  
278 Meeting.

279 **SECTION B. VALIDATION AND PLACEMENT ON BALLOT**

280 1. The Administrative Staff shall verify that all signatures on the petition are valid. “Valid” is  
281 defined as the person who is seeking nomination and the persons who signed the petition are  
282 Fellows as defined in the FSMB Bylaws.

283 2. Once verified, the petitions are deemed valid and the candidate is placed on the ballot.

284 3. The names of those seeking to run by petition whose petitions are deemed valid shall be  
285 distributed to the Voting Delegates not fewer than 14 days prior to the Annual Meeting.

286 4. Once a candidate seeking to run by petition is added to the ballot, the candidate shall be  
287 afforded the same privileges and be bound by the same rules in the campaign process as  
288 candidates who were nominated by the Nominating Committee.

289 **ARTICLE VI. PRESIDENT**

290 The Board of Directors may, by a two-thirds majority vote of the full Board, appoint a President of  
291 the FSMB, who shall be a physician, to serve without term. The President shall administer the  
292 affairs of the FSMB and shall have such duties and responsibilities as the Board of Directors and

293 the FSMB shall direct. The President shall serve as Secretary of the FSMB and shall be an ex-  
 294 officio member, without vote, of the Board of Directors.

295 **ARTICLE VII. MEETINGS**

296 **SECTION A. ANNUAL MEETING OF THE HOUSE OF DELEGATES**

297 The annual meeting of the House of Delegates of the FSMB, which shall be called the House of  
 298 Delegates, shall be held at such time and place as may be fixed by the Board of Directors. Written  
 299 notice of the time and place of the meeting shall be given to all Member Medical Boards by mail  
 300 not fewer than 90 days prior to the date of the meeting.

301 **SECTION B. SPECIAL MEETINGS OF THE HOUSE OF DELEGATES**

302 Special meetings of the House of Delegates may be called at any time by the Chair, on the written  
 303 request of ten Member Medical Boards or by action of the Board of Directors. Written notice of the  
 304 time and place of such meetings shall be given to all Member Medical Boards by mail not fewer  
 305 than 30 days prior to the date of the meeting.

306 **SECTION C. RIGHT TO VOTE**

- 307 1. The right to vote at meetings of the House of Delegates is vested in, and restricted to, Member  
 308 Medical Boards. Each Member Medical Board is entitled to one vote, said vote to be cast by  
 309 the delegate of the Member Board. The delegate shall be the president of the Member Medical  
 310 Board or the President’s designated alternate. In order for a delegate to be permitted to vote,  
 311 the delegate shall present a letter of appointment to the Secretary of the Board of Directors.
- 312 2. All classes of membership shall have the right of the floor at meetings of the House upon  
 313 request of a delegate and approval of the presiding officer; however, the right to introduce  
 314 resolutions is restricted to Member Medical Boards and the Board of Directors and the  
 315 procedure for submission of such resolutions shall be in accordance with FSMB Policy.

316 **SECTION D. QUORUM**

317 A majority of Member Medical Boards shall constitute a quorum at any meeting of the House of  
 318 Delegates. A majority of the voting members of the Board of Directors or any committee or other  
 319 constituted group shall constitute a quorum of the Board, committee or group.

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322 **SECTION E. RULES OF ORDER**

323 Meetings of the House of Delegates, Board of Directors and all committees shall be conducted in  
324 accordance with the *American Institute of Parliamentarians Standard Code of Parliamentary*  
325 *Procedure*, current edition, except when in conflict with the Articles of Incorporation or these  
326 Bylaws, in which case the Articles of Incorporation or these Bylaws shall prevail.

327 **ARTICLE VIII. STANDING AND SPECIAL COMMITTEES**

328 **SECTION A. STANDING COMMITTEES**

- 329 1. The Standing Committees of the FSMB shall be:
  - 330 a. Audit Committee
  - 331 b. Bylaws Committee
  - 332 c. Editorial Committee
  - 333 d. Education Committee
  - 334 e. Ethics and Professionalism Committee
  - 335 f. Finance Committee
  - 336 g. Nominating Committee
- 337 2. **ADDITIONAL STANDING COMMITTEES.** Additional standing committees may be created by  
338 resolution of the FSMB and/or amendment to the Bylaws. Chairs and members of all standing  
339 committees, with the exception of the Nominating Committee, shall be appointed by the Chair,  
340 with the approval of the Board of Directors, for a term of one year, unless otherwise provided  
341 for in these Bylaws. Reappointment, unless specifically prohibited, is permissible.
- 342 3. **MEMBERSHIP.** Honorary Fellows, Associate Members and Courtesy Members may be  
343 appointed by the Chair to serve on a standing committee in addition to the number of committee  
344 members called for in the following sections of this chapter. No more than one Honorary  
345 Fellow, Associate or Courtesy Member or non-member subject matter expert may be  
346 appointed by the Chair to serve in such a capacity on any standing committee unless otherwise  
347 provided for in these Bylaws. All committee members shall serve with vote. Honorary Fellows,  
348 Associate or Courtesy Members, and non-members appointed to standing committees by the  
349 Chair shall serve for a term concurrent with the term of the Chair. No individual shall serve on  
350 more than one standing committee except as specified in the Bylaws. With the exception of  
351 the Nominating Committee and the Editorial Committee, the Chair and the Chair-elect shall  
352 serve, ex-officio, on all committees.

353 4. VACANCIES. In the event a vacancy occurs in an elected position on a standing committee, the  
354 Chair, with the approval of the Board of Directors, shall appoint a Fellow to serve on the  
355 committee until the next meeting of the House of Delegates, at which time an election will be  
356 held to fill the vacant position for the remainder of the unexpired term. In the event a vacancy  
357 occurs in an appointed position on a standing committee, the Chair, with the approval of the  
358 Board of Directors, shall appoint a Fellow to serve on the committee for the remainder of the  
359 unexpired term. In the event the Chairmanship of the Nominating Committee becomes vacant,  
360 the FSMB Chair, with the approval of the FSMB Board of Directors, shall appoint a Past Chair  
361 of the FSMB Board of Directors to serve in that capacity for the remainder of the unexpired  
362 term.

### 363 **SECTION B. AUDIT COMMITTEE**

364 The Audit Committee shall:

- 365 1. Be composed of five Fellows, three of whom shall be members of the Board of Directors. The  
366 Treasurer of the FSMB shall serve ex-officio without vote. The Chair of the FSMB shall appoint  
367 the Chair of the Audit Committee from one of the three sitting Board Members.
- 368 2. Ensure that an annual audit of the financial accounts and records of the FSMB is performed  
369 by an independent Certified Public Accounting firm.
- 370 3. Recommend to the Board of Directors the appointment, retention or termination of an  
371 independent auditor or auditors and develop a schedule for periodic solicitation of audit firms  
372 consistent with Board policies and best practices.
- 373 4. Oversee the independent auditors. The independent auditors shall report directly to the  
374 Committee.
- 375 5. Review the audit of the FSMB. Submit such audit and Committee's report to the Board of  
376 Directors.
- 377 6. Report any suggestions to the Board of Directors on fiscal policy to ensure the continuing  
378 financial strength of the FSMB.
- 379 7. When the finalized committee report to the Board of Directors is made, suggestions and  
380 feedback will be forwarded to the Finance Committee.

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383 **SECTION C. BYLAWS COMMITTEE**

384 The Bylaws Committee, composed of five Fellows, shall continually assess the Articles of  
385 Incorporation and the Bylaws and shall receive all proposals for amendments thereto. It shall, from  
386 time to time, make recommendations to the House of Delegates for changes, deletions,  
387 modifications and interpretations thereto.

388 **SECTION D. EDITORIAL COMMITTEE**

389 1. An Editorial Committee, not to exceed twelve Fellows and three non-member subject matter  
390 experts, shall advise the Editor-in-Chief on editorial policy for the FSMB’s official publication,  
391 and shall serve as the editorial board of that publication and otherwise assist the Editor-in-  
392 Chief in the performance of duties as appropriate and necessary. No officer or member of the  
393 Board of Directors shall serve on this Committee.

394 2. Service on the Editorial Committee is by nomination and appointment by the FSMB Chair,  
395 subject to approval of the Board of Directors, immediately following the Annual Meeting of the  
396 House of Delegates. Candidates are allowed to express their interest in serving on the  
397 Committee through self-nomination. Committee members shall serve staggered three-year  
398 terms and shall be limited to two full terms.

399 3. The Editor-in-Chief shall be elected by the Editorial Committee to a three-year term beginning  
400 on the date of the annual Editorial Committee meeting, with the Editor-in-Chief’s term on the  
401 Editorial Committee being automatically extended to allow the Editor-in-chief to serve for three  
402 years. A member of the Editorial Committee whose term is expiring shall continue to serve until  
403 the member’s replacement meets at the next annual Editorial Committee meeting.

404 4. The Editorial Committee will elect its Chair, who will serve as the Editor-in-Chief of the *Journal*  
405 *of Medical Regulation*. The Editor-in-Chief will serve without compensation and will coordinate  
406 decisions on the *Journal* content, among other duties to be determined by the Bylaws  
407 Committee.

408 **SECTION E. EDUCATION COMMITTEE**

409 The Education Committee shall be composed of eight Fellows, to include the Chair as chair, the  
410 Immediate Past Chair and the Chair-elect. The Committee shall be responsible for assisting in the  
411 development of educational programs for the FSMB.

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413 **SECTION F. ETHICS AND PROFESSIONALISM COMMITTEE**

414 The Ethics and Professionalism Committee shall be composed of up to five Fellows and up to two  
415 subject matter experts. The Ethics and Professionalism Committee shall address ethical and  
416 professional issues pertinent to medical regulation.

417 **SECTION G. FINANCE COMMITTEE**

418 The Finance Committee shall be composed of five Fellows, to include the Treasurer as Chair. The  
419 Finance Committee shall review the financial condition of the FSMB, review and evaluate the costs  
420 of the activities and programs to be undertaken in the forthcoming year, present a budget for the  
421 FSMB to the Board of Directors for its recommendation to the House of Delegates at the Annual  
422 Meeting and perform such other duties as are assigned to it by the Board of Directors. Except for  
423 the Treasurer, no Fellow shall serve on both the Audit and Finance Committees.

424 **SECTION H. NOMINATING COMMITTEE: PROCESS FOR ELECTION**

- 425 1. MEMBERSHIP: The Nominating Committee shall be composed of six Fellows and the Immediate  
426 Past Chair, who shall chair the Committee and serve without vote except in the event of a tie.  
427 At least one elected member of the Nominating Committee shall be a public member. With  
428 the exception of the Immediate Past Chair, no two Committee members shall be from the  
429 same member board and no officer or member of the Board of Directors shall serve on the  
430 Committee. A member of the Nominating Committee may not serve consecutive terms.
- 431 2. ELECTION: At least three Fellows shall be elected at each Annual Meeting of the House of  
432 Delegates by a plurality of votes cast, each to serve for a term of two years. Only an individual  
433 who is a Fellow at the time of the individual’s election shall be eligible for election as a member  
434 of the Nominating Committee. In the event of a tie vote in a runoff election, up to two additional  
435 runoff elections shall be held. Prior to the election, the presiding officer shall cast a sealed  
436 vote, ranking each candidate in a list. The presiding officer’s vote is counted for the candidate  
437 in the runoff election who is highest on the list. The presiding officer’s vote is counted only to  
438 resolve a tie that cannot be decided by the process set forth in this section.
- 439 3. Members of the Nominating Committee are not eligible for inclusion on the roster of candidates  
440 for offices and positions to be filled by election at the Annual Meeting of the House of  
441 Delegates.

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444 **SECTION I. SPECIAL COMMITTEES**

445 Special committees may be appointed by the Chair, from time to time, as may be necessary for a  
446 specific purpose.

447 **SECTION J. REPRESENTATIVES TO OTHER ORGANIZATIONS AND ENTITIES**

448 Appointment of all representatives of the FSMB to other official organizations or entities shall be  
449 made or nominated by the Chair, with the approval of the Board of Directors, as applicable, and  
450 shall serve for a term of three years unless the other organization shall specify some other term  
451 of appointment. Representatives to these organizations shall be Fellows, Honorary Fellows,  
452 Associate Members or Courtesy Members at the time of their appointment or nomination.

453 **ARTICLE IX. UNITED STATES MEDICAL LICENSING EXAMINATION (USMLE)**

454 **SECTION A.** Except as otherwise set forth in this Article, the composition of committees and  
455 subcommittees for the USMLE are subject to agreements with and the advice and consent of the  
456 National Board of Medical Examiners (NBME) and/or the USMLE Composite Committee. The  
457 Chair, with the approval of the Board of Directors, shall make appointments to the following  
458 USMLE committees in appropriate numbers and at appropriate times as required by the  
459 FSMB/NBME Agreement establishing the USMLE and by other agreements as may apply:

- 460 1. USMLE Composite Committee, which shall be responsible for the development, operation and  
461 maintenance of policies governing the three-step USMLE. The President shall be one of the  
462 FSMB's representatives on this Committee.
- 463 2. USMLE Budget Committee, which shall be responsible for the development and monitoring of  
464 USMLE revenues and expenses, including the establishment of fees. FSMB representatives  
465 on the Committee will be the Chair, Chair-elect, Treasurer, President and the senior FSMB  
466 financial staff member.
- 467 3. The USMLE Management Committee shall be responsible for overseeing the design,  
468 development, scoring and standard setting for the USMLE Step examinations, subject to  
469 policies established by and reporting to the USMLE Composite Committee. Appointments to  
470 the Management Committee shall be made consistent with the FSMB/NBME Agreement  
471 Establishing the USMLE.

472 **SECTION B.** The President shall provide FSMB advice and consent to the NBME for NBME's  
473 appointments to the USMLE Management Committee and/or any appointments made jointly under  
474 the FSMB/NBME Agreement Establishing the USMLE.

475 **ARTICLE X. POST-LICENSURE ASSESSMENT SYSTEM**

476 The Post-Licensure Assessment Governing Committee shall be responsible for the development,  
477 operation and maintenance of policies governing the Post-Licensure Assessment System (PLAS)  
478 established by joint agreement between FSMB and NBME. The Chair, with the approval of the  
479 Board of Directors, shall make appointments to the Post-Licensure Assessment Governing  
480 Committee and its program committees in appropriate numbers and at appropriate times as  
481 required by the FSMB/NBME joint agreement establishing the Post-Licensure Assessment  
482 System and by other agreements as may apply.

483 **ARTICLE XI. FINANCES AND DUES**

484 **SECTION A. SOURCES OF FUNDS**

485 Funds necessary for the conduct of the affairs of the FSMB shall be derived from but not be limited  
486 to:

- 487 1. Annual dues imposed on the Member Medical Boards, Affiliate Members, Courtesy Members  
488 and Official Observers;
- 489 2. Special assessments established by the House of Delegates;
- 490 3. Voluntary contributions, devices, bequests and other gifts;
- 491 4. Fees charged for examination services, data base services, credentials verification services  
492 and publications.

493 **SECTION B. ANNUAL DUES, ELIGIBILITY TO SERVE AS A DELEGATE**

494 The annual dues for Member Medical Boards shall be established, from time to time, by a majority  
495 vote of the House of Delegates.

- 496 1. Annual dues for Member Medical Boards shall be the same for all Members regardless of their  
497 physician populations. Annual dues are due and payable not later than January 1.
- 498 2. Any Member Medical Board whose dues are in default at the time of the Annual Meeting of the  
499 House of Delegates shall be ineligible to have a seated delegate.

500 **ARTICLE XII. DISCIPLINARY ACTION**

501 **SECTION A. MEMBER**

502 For the purposes of this Article, a member shall be defined as a Member Medical Board, a Fellow,  
503 an Honorary Fellow, an Associate Member, an Affiliate Member, Courtesy Member or Official  
504 Observer.

505 **SECTION B. AUTHORIZATION**

506 The Board of Directors, on behalf of the House of Delegates, may enforce disciplinary measures,  
507 including expulsion, suspension, censure and reprimand, and impose terms and conditions of  
508 probation or such sanctions as it may deem appropriate, for any of the following reasons:

- 509 1. Failure of the member to comply or act in accordance with these Bylaws, the Articles of  
510 Incorporation of the FSMB, or other duly adopted rules or regulations of the FSMB;
- 511 2. Failure of the member to comply with any contract or agreement between the FSMB and such  
512 member or with any contract or agreement of the FSMB that binds such member;
- 513 3. Failure of the member to maintain confidentiality or security, or the permitting of conditions that  
514 allow a breach of confidentiality or security, in any manner dealing with the licensing  
515 examination process or the confidentiality of FSMB records, including the storage,  
516 administration, grading or reporting of examinations and information relating to the examination  
517 process; or
- 518 4. The imposition of a sanction, judgment, disciplinary penalty or other similar action by a Member  
519 Medical Board that licenses the member or by a state or federal court, or other competent  
520 tribunal, whether or not related to the practice of medicine and including conduct as a member  
521 of a Member Medical Board.

522 **SECTION C. PROCEDURE**

523 Any member alleged to have acted in such manner as to be subject to disciplinary action shall be  
524 accorded, at a minimum, the procedural protection set forth in the Manual for Disciplinary  
525 Procedures, which is available from the FSMB upon the written request of any member.

526 **SECTION D. REINSTATEMENT**

527 In the event a member is suspended or expelled from the FSMB, the member may apply to the  
528 President for reinstatement after one year following final action on expulsion. The President shall  
529 review the application and the reason for the suspension or expulsion and forward a report to the

530 Board. The Board may accept application for reinstatement under such terms and conditions as it  
 531 may deem appropriate, reject the application or request further information from the President.  
 532 The Board's decision to accept or reject an application is final.

### 533 **ARTICLE XIII. CORPORATE SEAL**

534 The Board of Directors shall adopt a corporate seal that meets the requirements of the state in  
 535 which the FSMB is incorporated.

### 536 **ARTICLE XIV. ADOPTION AND AMENDMENT OF BYLAWS, EFFECTIVE DATE**

#### 537 **SECTION A. AMENDMENT**

538 These Bylaws may be amended at any annual meeting of the House of Delegates by two-thirds  
 539 of those present and voting. Bylaws changes may be proposed only by the Board of Directors,  
 540 Member Medical Boards or the Bylaws Committee. All such proposals must be submitted in writing  
 541 to the Bylaws Committee, in care of the Secretary of the FSMB. The Bylaws Committee shall  
 542 inform the Member Medical Boards of its meeting dates not fewer than 60 days in advance of the  
 543 meeting. The recommendations of the Bylaws Committee and the full texts of all proposed  
 544 amendments recommended to the Committee shall be sent to each Member Medical Board not  
 545 fewer than 60 days prior to the Annual Meeting of the House of Delegates at which they are to be  
 546 considered.

#### 547 **SECTION B. EFFECTIVE DATE**

548 These Bylaws and any other subsequent amendments thereto, shall become effective upon their  
 549 adoption, except as otherwise provided herein.

550

551

Bylaws last amended in April 2017

## **Attachment 2**

**2018 FSMB BYLAWS**  
**PROPOSED AMENDMENTS**  
**PROPOSAL #2**

**ARTICLE I. NAME**

The corporation shall be known as the Federation of State Medical Boards of the United States, Inc. ("FSMB").

**ARTICLE II. CLASSES OF MEMBERSHIP, ELECTION AND MEMBERSHIP RIGHTS**

**SECTION A. MEMBER MEDICAL BOARDS**

The term "Member Medical Board" as used in the Articles of Incorporation and in these Bylaws shall refer to any board, committee or other group in any state, territory, the District of Columbia or possession of the United States of America that is empowered by law to pass on the qualifications of applicants for licensure to practice allopathic or osteopathic medicine or to discipline such licensees. If a state or other jurisdiction has more than one such entity and if each is an independent agency unrelated to the others, each is eligible for membership. Any eligible Medical Board may become a Member Medical Board upon approval of its application by the Board of Directors.

**SECTION B. FELLOWS**

An individual member who as a result of appointment or confirmation is designated to be a member of a Member Medical Board shall be a Fellow of the FSMB during the member's period of service on a Member Medical Board, and for a period of ~~36~~ thirty-six months thereafter.

**SECTION C. HONORARY FELLOWS**

Thirty-six months after completion of service on a Member Medical Board, a Fellow shall become an Honorary Fellow of the FSMB and may be appointed by the Chair to serve as a member of any committee or in any other appointive capacity.

**SECTION D. ASSOCIATE MEMBERS**

A Member Medical Board may designate one or more employees or staff members to be an Associate Member of the FSMB. No Associate Member shall continue in that capacity upon termination of employment by or service to the Member Medical Board.

30 **SECTION E. COURTESY MEMBERS**

31 Any physician or physician assistant licensed by a Member Medical Board or an Affiliate Member  
 32 Board and not eligible for any other type of membership may become a Courtesy Member of the  
 33 FSMB upon approval of the candidate’s application. A Courtesy Member may serve as a member  
 34 of a committee and in any other capacity upon appointment by the Chair.

35 **SECTION F. AFFILIATE MEMBERS BOARDS**

36 A board or authority that is not otherwise eligible for membership may become an Affiliate Member  
 37 Board of the FSMB upon approval of its application by the Board of Directors if the board or  
 38 authority licenses either:

- 39 1. Allopathic or osteopathic physicians or physician assistants in the United States; or
- 40 2. Allopathic or osteopathic physicians if the board or authority is located in another country.

41 **SECTION G. OFFICIAL OBSERVERS**

42 An organization may apply for Official Observer status at meetings of the House of Delegates.  
 43 The Board of Directors shall prescribe rules and procedures to govern the application for, the  
 44 granting of and the exercise of Official Observer status.

45 **SECTION H. RIGHTS OF MEMBERS**

46 Except as otherwise provided in these Bylaws, rights, duties, privileges and obligations of a  
 47 member of the FSMB may be exercised only by a Member Medical Board.

48 **SECTION I. METHODS OF NOMINATION TO ELECTED OFFICE**

49 Nomination by the Nominating Committee or Nomination by Petition pursuant to Articles III, IV, V  
 50 and VIII shall be the sole methods of nomination to an elected office of the FSMB. A candidate  
 51 who runs for and is not elected to an elected office shall be ineligible to be nominated for any other  
 52 elected office during the same election cycle.

53 **ARTICLE III. OFFICERS: ELECTION AND DUTIES**

54 **SECTION A. OFFICERS OF THE FSMB**

- 55 1. OFFICERS. The officers of the FSMB shall be that of Chair, Chair-elect, Immediate Past Chair,  
 56 Treasurer and Secretary.

57 2. Only an individual who is a Fellow at the time of the individual's election or appointment shall  
 58 be eligible for election or appointment as an Officer of the FSMB, except for the position of  
 59 Secretary.

60 3. The position of Secretary shall be an ex-officio office, without vote, and the President of the  
 61 FSMB shall serve as Secretary.

62 **SECTION B. ELECTION OF OFFICERS**

63 1. The Chair-elect shall ascend to the position of Chair at the Annual Meeting following the  
 64 meeting in which the Chair-elect was elected.

65 2. The Chair-elect shall be elected at each Annual Meeting of the House of Delegates.

66 **3. The Immediate Past Chair assumes that position upon the Chair-elect ascending to the**  
 67 **position of Chair.**

68 ~~3~~ **4.** The Treasurer shall be elected every third year at the Annual Meeting of the House of  
 69 Delegates.

70 ~~4~~ **5.** Officers shall be elected by a majority of the members of the House of Delegates present and  
 71 voting.

72 ~~5~~ **6.** In any election, should no candidate receive a majority of the votes cast, a runoff election shall  
 73 be held between the two candidates who receive the most votes for that office on the first  
 74 ballot. Up to two additional runoff elections shall be held.

75 ~~6~~ **7.** Prior to each election, the presiding officer shall cast a sealed vote that shall be counted only  
 76 to resolve a tie that cannot be decided by the process set forth in this section.

77 **SECTION C. DUTIES OF OFFICERS**

78 1. The duties of the Chair shall be as follows:

79 a. Preside at all meetings and sessions of the House of Delegates and the Board of Directors;

80 b. Perform the duties customary to the office of the Chair;

81 c. Make appointments to committees and define duties of committee members in accordance  
 82 with these Bylaws, except as otherwise provided herein;

83 d. Serve, ex officio, on all committees except as otherwise provided herein; and

84 e. Exercise such other rights and customs as the Bylaws and parliamentary usage may  
 85 require or as the FSMB or the Board of Directors shall deem appropriate.

86 2. The duties of the Chair-elect shall be as follows:

87 a. Assist the Chair in the discharge of the Chair’s duties; and

88 b. Perform the duties of the Chair at the Chair’s request or, in the event of the Chair’s  
 89 temporary absence or incapacitation, at the request of the Board of Directors.

90 **3. The duties of the Immediate Past Chair shall be as follows:**

91 **a. Assist the Chair in the transition from Chair-elect to Chair;**

92 **b. Serve as chair of the Nominating Committee; and**

93 **c. Perform such other duties and responsibilities as the Chair shall determine.**

94 **3 4.**The duties of the Treasurer shall be as follows:

95 a. Perform the duties customary to that office;

96 b. Perform such other duties as the Bylaws and custom and parliamentary usage may require  
 97 or as the Board of Directors shall deem appropriate;

98 c. Serve as an ex officio member of the Audit Committee; and

99 d. Serve as chair of the Finance Committee.

100 **4 5.**The duties of the Secretary shall be as follows:

101 a. Administer the affairs of the FSMB; and

102 b. Such duties and responsibilities as the FSMB and the Board of Directors shall determine.

103 **SECTION D. TERMS OF OFFICE AND SUCCESSION**

104 1. The Chair and Chair-elect shall serve for single terms of one year or until their successors  
 105 assume office.

106 **2. The Immediate Past Chair shall serve until a successor to the current Chair assumes**  
 107 **office.**

108 **2 3.**The Treasurer shall serve for a single term of three years or until the Treasurer’s successor  
 109 assumes the office.

110 **3 4.**Officers shall assume office upon final adjournment of the Annual Meeting of the House of  
 111 Delegates at which they were elected.

112 **4 5.**The term of the Secretary is co-terminus with that of the President.

113 **SECTION E. VACANCIES**

114 1. In the event of a vacancy in the office of the Chair, the Chair-elect shall assume the position of  
 115 Chair for the remainder of the unexpired term, and shall then serve a full one-year term as  
 116 Chair.

117 2. In the event of a vacancy in the office of the Chair-elect, the Board of Directors shall appoint a  
 118 Director-at-Large to assume the duties, but not the office, of Chair-elect for the remainder of  
 119 the unexpired term. At the next Annual Meeting of the House of Delegates, both a Chair and a  
 120 Chair-elect shall be elected in accordance with the provisions in Section B of this Article.

121 **3. In the event of a vacancy in the office of Immediate Past Chair, the office shall remain**  
 122 **open until a new Chair assumes the office.**

123 **3 4.**In the event of a vacancy in the office of the Treasurer, the Board of Directors shall elect one  
 124 of the Directors-at-Large to serve as Treasurer, with one vote on the Board of Directors and  
 125 one vote on the Executive Committee, until the next year's Annual Meeting of the House of  
 126 Delegates, at which time a Treasurer shall be elected.

127 **ARTICLE IV. BOARD OF DIRECTORS**

128 **SECTION A. MEMBERSHIP AND TERMS**

129 1. MEMBERSHIP: The Board of Directors shall be composed of the Officers, ~~the Immediate Past~~  
 130 **Chair**, nine Directors-at-Large and two Associate Members. At least two members of the  
 131 Board, who are not Associate Members, shall be non-physicians, at least one of whom shall  
 132 be a public/consumer member.

133 2. NOMINATION OF ASSOCIATE MEMBERS: Nominations for Associate Member positions shall be  
 134 accepted from Member Boards, the Board of Directors and Administrators in Medicine (AIM).  
 135 Associate Members shall be elected by the Board of Directors in staggered terms in  
 136 accordance with policies and procedures established by the Board of Directors.

137 3. TERMS: Directors-at-Large shall each serve for a term of three years and shall be eligible to be  
 138 reelected to one additional term. A partial term totaling one-and-a-half years or more shall  
 139 count as a full term. Associate Members shall each serve for a term of two years. Associate  
 140 Members shall not be eligible to serve consecutive terms.

141 **SECTION B. NOMINATIONS**

- 142 1. The Nominating Committee shall submit a roster of one or more candidates for each of the  
 143 offices and positions to be filled by election at the Annual Meeting of the House of Delegates.
- 144 2. The Nominating Committee shall mail its roster of candidates to Member Boards not fewer  
 145 than ~~60~~ sixty days prior to the Annual Meeting of the House of Delegates.

146 **SECTION C. ELECTION OF DIRECTORS-AT-LARGE**

- 147 1. At least three of the Directors-at-Large shall be elected each year at the Annual Meeting of the  
 148 House of Delegates by a majority of the votes cast.
- 149 2. If no candidate receives a majority of the votes on the first ballot, and one seat is to be filled, a  
 150 runoff election shall be held between the two candidates who received the most votes on the  
 151 first ballot.
- 152 3. If more than one seat is to be filled from a single list of candidates, and if one or more seats  
 153 are not filled by majority vote on the first ballot, a runoff election shall be held, with the ballot  
 154 listing candidates equal in number to twice the number of seats remaining to be filled. These  
 155 candidates shall be those remaining who received the most votes on the first ballot. The same  
 156 procedure shall be used for any required subsequent runoff elections. In the event of a tie vote  
 157 in a runoff election up to two additional runoff elections shall be held.
- 158 4. Prior to the election, the presiding officer shall cast a sealed vote, ranking each candidate in a  
 159 list. The presiding officer's vote is counted for the candidate in the runoff election who is highest  
 160 on the list. The presiding officer's vote is counted only to resolve a tie that cannot be decided  
 161 by the process set forth in this section.
- 162 5. Directors shall assume office upon final adjournment of the Annual Meeting of the House of  
 163 Delegates at which they were elected.
- 164 6. Only an individual who is a Fellow at the time of the individual's election shall be eligible for  
 165 election as a Director of the FSMB.

166 **SECTION D. DUTIES OF THE BOARD OF DIRECTORS**

- 167 1. The control and administration of the FSMB is vested in the Board of Directors and it shall act  
 168 for the FSMB between Annual Meetings.
- 169 2. The Board of Directors shall carry out the mandates of the FSMB as established by the House  
 170 of Delegates, and it shall have full and complete ~~power and~~ authority to perform all acts and  
 171 to transact all business for and on behalf of the FSMB.
- 172 3. The Board of Directors shall conduct and manage all property, affairs, work and activities of  
 173 the FSMB, subject only to the provisions of the Articles of Incorporation and these Bylaws, and  
 174 to resolutions and enactments of the House of Delegates.
- 175 4. The Board of Directors shall be the fiscal agent of the FSMB.
- 176 5. The Board of Directors shall establish rules for its operations and meetings.
- 177 6. The FSMB shall indemnify Directors, Officers and other individuals acting on behalf of the  
 178 FSMB if such indemnification is in accordance with the laws of the State of Nebraska and the  
 179 operational policies and procedures of the Board of Directors, as adopted. The Board shall  
 180 report to the membership of the FSMB at the Annual Meeting of the House of Delegates.
- 181 7. The Board of Directors shall establish a strategic plan for the FSMB that states the FSMB  
 182 mission and objectives and shall submit that plan to the House of Delegates for ratification,  
 183 modification or rejection. The Board shall review the current strategic plan annually and  
 184 propose any amendments to the Annual Meeting of the House of Delegates for ratification,  
 185 modification or rejection. The President shall report to the Annual Meeting of the House of  
 186 Delegates on the extent to which the FSMB's stated objectives have been accomplished in the  
 187 preceding year.

188 **SECTION E. REMOVAL FROM OFFICE**

- 189 1. REMOVAL: Any officer or member of the Board of Directors may be removed for any cause  
 190 deemed sufficient by an affirmative vote of two-thirds of the total members of the Board of  
 191 Directors entitled to vote and who are not subject to removal from office.
- 192 2. PROCEDURE: The procedure for removal shall be as follows:
- 193 a. The Board shall file with the Secretary of the Board and deliver a written statement of the  
 194 cause for removal to the officer or board member in sufficient detail as to state the grounds

195 for the removal. Delivery to the officer or **board** member shall be by certified mail, return  
 196 receipt requested, to the last address known to the Board ~~and is effective upon mailing.~~

197 b. The officer or board member shall deliver a sworn written response to the Board, no later  
 198 than thirty calendar days after the written statement **of the cause for removal** is filed with  
 199 ~~the Secretary of the Board~~ **delivered to the officer or board member in question.**  
 200 Delivery to the Board shall be by certified mail, return receipt requested, directed to the  
 201 Secretary of the Board at the FSMB corporate office. ~~Delivery is effective upon mailing.~~

202 c. At the ~~next~~ Board meeting **following the date the response is due**, the Board shall  
 203 determine whether or not to proceed with removal. Notice of the Board’s action shall be  
 204 delivered to the officer or ~~B~~**b**oard member by certified mail, return receipt requested. If the  
 205 officer or board member ~~did~~ **does** not file a written response the Board shall proceed with  
 206 a determination. ~~Delivery is effective upon mailing.~~

207 d. If the Board votes to proceed with removal of the officer or ~~B~~**b**oard member, at a Board  
 208 meeting ~~held no less than thirty days after delivery of the notice~~, the ~~B~~**b**oard member  
 209 shall be afforded the opportunity to address the Board on the merits of the allegations and  
 210 produce any relevant information to the Board after which the Board shall make a  
 211 determination. **The Board meeting at which the officer or board member has the**  
 212 **opportunity to address the Board shall be held no less than thirty days after delivery**  
 213 **of the notice of removal.**

214 3. APPEAL: Any officer or member of the Board of Directors removed by the Board of Directors  
 215 may appeal to the House of Delegates at its next business meeting. The officer or member  
 216 may be reinstated by a two-thirds vote of the House of Delegates.

217 **4. Delivery. For the purposes of this section, “Delivery” is effective upon mailing.**

218 **SECTION F. VACANCIES**

219 1. DIRECTORS-AT-LARGE: In the event of a vacancy in the membership of the Directors-at-Large,  
 220 the Board of Directors may appoint a Fellow who meets the qualifications for the position to  
 221 serve until the next Annual Meeting of the House of Delegates, at which time ~~an individual a~~  
 222 **Fellow** shall be ~~nominated and, if~~ elected, ~~and~~ shall serve ~~for~~ the remainder of the unexpired  
 223 term. In the event a Director-at-Large is elected to the office of Treasurer or Chair-elect, that  
 224 vacancy shall be filled by an election at the same Annual Meeting of the House of Delegates.

225 2. ASSOCIATE MEMBERS: In the event of a vacancy of an Associate Member, the Board of Directors  
 226 may appoint a substitute to complete the Associate Member’s term in accordance with the  
 227 policies established by the Board of Directors.

228 **SECTION G. EXECUTIVE COMMITTEE OF THE BOARD**

229 1. MEMBERSHIP: The Board of Directors shall establish an Executive Committee of the Board,  
 230 which shall consist of the Chair as Chair, Chair-elect, Treasurer, Immediate Past Chair and  
 231 ~~two~~ **three** Directors-at-Large. The Directors-at-Large shall be elected for a one-year term by  
 232 majority vote of the Directors-at-Large and the Associate Members of the Board of Directors  
 233 at the first regular meeting of the Board following the Annual Meeting of the House of  
 234 Delegates. In the event of a vacancy in a Director-at-Large position, the Directors-at-Large and  
 235 the Associate Members of the Board, by majority vote, shall choose another Director-at-Large  
 236 to serve the remainder of the one-year term. In the event of vacancy in the position of  
 237 Immediate Past Chair, this position shall remain vacant until the next Annual Meeting of the  
 238 House of Delegates.

239 2. DUTIES: In intervals between Board meetings, the Executive Committee shall act for and on  
 240 behalf of the Board in any matters that require prompt attention. It shall not modify actions  
 241 previously taken by the Board unless additional information or a change of circumstances is  
 242 presented and warrants additional action.

243 3. MEETINGS: The Executive Committee may meet as often as it deems necessary or appropriate,  
 244 either in person, telephonically, electronically or by unanimous written consent, and at such  
 245 times and places and manner as the Chair may determine. Minutes must be kept of all  
 246 meetings.

247 4. REPORTING: The Executive Committee shall report in writing all formal actions taken by it to the  
 248 Board of Directors within five working days of taking those actions. At each meeting of the  
 249 Board, the Executive Committee shall present to the Board a written report of all its formal  
 250 actions since the previous meeting of the Board.

251 **SECTION H. PUBLIC POLICY STATEMENTS**

252 A “public policy” is defined as the official public position of the FSMB on a matter that may be  
 253 reasonably expected to affect Member Boards when dealing with their licensees, other health care  
 254 providers, health-related special interest groups, governmental bodies or the public. The House

255 of Delegates is the official public policy-making body of the FSMB. When the interests of the FSMB  
 256 require more immediate action, the Board of Directors, or the President in consultation with the  
 257 Chair, if feasible, is authorized to issue statements on matters of public policy between Annual  
 258 Meetings.

259 **ARTICLE V. NOMINATION BY PETITION FOR BOARD OF DIRECTORS AND NOMINATING**  
 260 **COMMITTEE**

261 **SECTION A. SUBMISSION OF A PETITION**

- 262 1. At the time the Nominating Committee’s roster of candidates is distributed to the Member  
 263 Boards, the Boards will be informed that a Fellow who is qualified for nomination, but not  
 264 otherwise nominated by the Nominating Committee, may seek to run for a position on the  
 265 Board of Directors as an Officer or Director-at-Large, or for a position on the Nominating  
 266 Committee.
- 267 2. In order to be placed on the ballot, the Fellow seeking nomination is required to present a  
 268 petition to Administrative Staff that is signed by at least one Fellow from at least four Member  
 269 Boards as well as a fellow from the Board of the member seeking nomination.
- 270 3. The deadline to submit petitions to the Administrative Staff is **21 twenty-one** days prior to the  
 271 Annual Meeting.

272 **SECTION B. VALIDATION AND PLACEMENT ON BALLOT**

- 273 1. The Administrative Staff shall verify that all signatures on the petition are valid. “Valid” is  
 274 defined as the person who is seeking nomination and the persons who signed the petition are  
 275 Fellows as defined in the FSMB Bylaws.
- 276 2. Once verified, the petitions are deemed valid and the candidate is placed on the ballot.
- 277 3. The names of those seeking to run by petition whose petitions are deemed valid shall be  
 278 distributed to the Voting Delegates not fewer than **14 fourteen** days prior to the Annual  
 279 Meeting.
- 280 4. Once a candidate seeking to run by petition is added to the ballot, the candidate shall be  
 281 afforded the same privileges and be bound by the same rules in the campaign process as  
 282 candidates who were nominated by the Nominating Committee.

283 **ARTICLE VI. PRESIDENT**

284 The Board of Directors may, by a two-thirds majority vote of the full Board, appoint a President of  
 285 the FSMB, who shall be a physician, to serve without term. The President shall administer the  
 286 affairs of the FSMB and shall have such duties and responsibilities as the Board of Directors and  
 287 the FSMB shall direct. The President shall serve as Secretary of the FSMB and shall be an ex-  
 288 officio member, without vote, of the Board of Directors.

289 **ARTICLE VII. MEETINGS**

290 **SECTION A. ANNUAL MEETING OF THE HOUSE OF DELEGATES**

291 The annual meeting of the House of Delegates of the FSMB, which shall be called the House of  
 292 Delegates, shall be held at such time and place as may be fixed by the Board of Directors. Written  
 293 notice of the time and place of the meeting shall be given to all Member Medical Boards by mail  
 294 not fewer than ~~90~~ ninety days prior to the date of the meeting. **Notice is effective upon mailing.**

295 **SECTION B. SPECIAL MEETINGS OF THE HOUSE OF DELEGATES**

296 Special meetings of the House of Delegates may be called at any time by the Chair, on the written  
 297 request of ten Member Medical Boards or by action of the Board of Directors. Written notice of the  
 298 time and place of such meetings shall be given to all Member Medical Boards by mail not fewer  
 299 than ~~30~~ thirty days prior to the date of the meeting. **Notice is effective upon mailing.**

300 **SECTION C. RIGHT TO VOTE**

- 301 1. The right to vote at meetings of the House of Delegates is vested in, and restricted to, Member  
 302 Medical Boards. Each Member Medical Board is entitled to one vote, said vote to be cast by  
 303 the delegate of the Member Board. The delegate shall be the president of the Member Medical  
 304 Board or the President’s designated alternate. In order for a delegate to be permitted to vote,  
 305 the delegate shall present a letter of appointment to the Secretary of the Board of Directors.
- 306 2. All classes of membership shall have the right of the floor at meetings of the House upon  
 307 request of a delegate and approval of the presiding officer; however, the right to introduce  
 308 resolutions is restricted to Member Medical Boards and the Board of Directors and the  
 309 procedure for submission of such resolutions shall be in accordance with FSMB Policy.

310

311 **SECTION D. QUORUM**

312 A majority of Member Medical Boards shall constitute a quorum at any meeting of the House of  
 313 Delegates. A majority of the voting members of the Board of Directors or any committee or other  
 314 constituted group shall constitute a quorum of the Board, committee or group.

315 **SECTION E. RULES OF ORDER**

316 Meetings of the House of Delegates, Board of Directors and all committees shall be conducted in  
 317 accordance with the *American Institute of Parliamentarians Standard Code of Parliamentary*  
 318 *Procedure*, current edition, except when in conflict with the Articles of Incorporation or these  
 319 Bylaws, in which case the Articles of Incorporation or these Bylaws shall prevail.

320 **ARTICLE VIII. STANDING AND SPECIAL COMMITTEES**

321 **SECTION A. STANDING COMMITTEES**

- 322 1. The Standing Committees of the FSMB shall be:
- 323 a. Audit Committee
  - 324 b. Bylaws Committee
  - 325 c. Editorial Committee
  - 326 d. Education Committee
  - 327 e. Ethics and Professionalism Committee
  - 328 f. Finance Committee
  - 329 g. Nominating Committee
- 330 2. **ADDITIONAL STANDING COMMITTEES.** Additional standing committees may be created by  
 331 resolution of the FSMB and/or amendment to the Bylaws. Chairs and members of all standing  
 332 committees, with the exception of the Nominating Committee, shall be appointed by the Chair,  
 333 with the approval of the Board of Directors, for a term of one year, unless otherwise provided  
 334 for in these Bylaws. Reappointment, unless specifically prohibited, is permissible.
- 335 3. **MEMBERSHIP.** Honorary Fellows, Associate Members and Courtesy Members may be  
 336 appointed by the Chair to serve on a standing committee in addition to the number of committee  
 337 members called for in the following sections of this chapter. No more than one Honorary  
 338 Fellow, Associate or Courtesy Member or non-member subject matter expert may be  
 339 appointed by the Chair to serve in such a capacity on any standing committee unless otherwise

provided for in these Bylaws. All committee members shall serve with vote. Honorary Fellows, Associate or Courtesy Members, and non-members appointed to standing committees by the Chair shall serve for a term concurrent with the term of the Chair. No individual shall serve on more than one standing committee except as specified in the Bylaws. With the exception of the Nominating Committee and the Editorial Committee, the Chair and the Chair-elect shall serve, *ex-officio*, on all committees.

4. VACANCIES. In the event a vacancy occurs in an elected position on a standing committee, the Chair, with the approval of the Board of Directors, shall appoint a Fellow to serve on the committee until the next meeting of the House of Delegates, at which time an election will be held to fill the vacant position for the remainder of the unexpired term. In the event a vacancy occurs in an appointed position on a standing committee, the Chair, with the approval of the Board of Directors, shall appoint a Fellow to serve on the committee for the remainder of the unexpired term. In the event the Chairmanship of the Nominating Committee becomes vacant, the FSMB Chair, with the approval of the FSMB Board of Directors, shall appoint a Past Chair of the FSMB Board of Directors to serve in that capacity for the remainder of the unexpired term.

**SECTION B. AUDIT COMMITTEE**

The Audit Committee shall:

1. Be composed of five Fellows, three of whom shall be members of the Board of Directors. The Treasurer of the FSMB shall serve *ex-officio* without vote. The Chair of the FSMB shall appoint the Chair of the Audit Committee from one of the three sitting Board Members.
2. Ensure that an annual audit of the financial accounts and records of the FSMB is performed by an independent Certified Public Accounting firm.
3. Recommend to the Board of Directors the appointment, retention or termination of an independent auditor or auditors and develop a schedule for periodic solicitation of audit firms consistent with Board policies and best practices.
4. Oversee the independent auditors. The independent auditors shall report directly to the Committee.
5. Review the audit of the FSMB. Submit such audit and Committee’s report to the Board of Directors.

370 6. Report any suggestions to the Board of Directors on fiscal policy to ensure the continuing  
 371 financial strength of the FSMB.

372 7. When the finalized committee report to the Board of Directors is made, suggestions and  
 373 feedback will be forwarded to the Finance Committee.

374 **SECTION C. BYLAWS COMMITTEE**

375 The Bylaws Committee, composed of five Fellows, shall continually assess the Articles of  
 376 Incorporation and the Bylaws and shall receive all proposals for amendments thereto. It shall, from  
 377 time to time, make recommendations to the House of Delegates for changes, deletions,  
 378 modifications and interpretations thereto.

379 **SECTION D. EDITORIAL COMMITTEE**

380 1. An Editorial Committee, not to exceed twelve Fellows and three non-member subject matter  
 381 experts, shall advise the Editor-in-Chief on editorial policy for the FSMB’s official publication,  
 382 and shall serve as the editorial board of that publication and otherwise assist the Editor-in-  
 383 Chief in the performance of duties as appropriate and necessary. No officer or member of the  
 384 Board of Directors shall serve on this Committee.

385 2. Service on the Editorial Committee is by nomination and appointment by the FSMB Chair,  
 386 subject to approval of the Board of Directors, immediately following the Annual Meeting of the  
 387 House of Delegates. Candidates are allowed to express their interest in serving on the  
 388 Committee through self-nomination. Committee members shall serve staggered three-year  
 389 terms and shall be limited to two full terms.

390 3. The Editor-in-Chief shall be elected by the Editorial Committee to a three-year term beginning  
 391 on the date of the annual Editorial Committee meeting, with the Editor-in-Chief’s term on the  
 392 Editorial Committee being automatically extended to allow the Editor-in-chief to serve for three  
 393 years. A member of the Editorial Committee whose term is expiring shall continue to serve until  
 394 the member’s replacement meets at the next annual Editorial Committee meeting.

395 4. The Editorial Committee will elect its Chair, who will serve as the Editor-in-Chief of the *Journal*  
 396 *of Medical Regulation*. The Editor-in-Chief will serve without compensation and will coordinate  
 397 decisions on the *Journal* content, among other duties to be determined by the Bylaws  
 398 Committee.

399 **SECTION E. EDUCATION COMMITTEE**

400 The Education Committee shall be composed of eight Fellows, to include the Chair as chair, the  
401 Immediate Past Chair and the Chair-elect. The Committee shall be responsible for assisting in the  
402 development of educational programs for the FSMB.

403 **SECTION F. ETHICS AND PROFESSIONALISM COMMITTEE**

404 The Ethics and Professionalism Committee shall be composed of up to five Fellows and up to two  
405 subject matter experts. The Ethics and Professionalism Committee shall address ethical and  
406 professional issues pertinent to medical regulation.

407 **SECTION G. FINANCE COMMITTEE**

408 The Finance Committee shall be composed of five Fellows, to include the Treasurer as Chair. The  
409 Finance Committee shall review the financial condition of the FSMB, review and evaluate the costs  
410 of the activities and programs to be undertaken in the forthcoming year, present a budget for the  
411 FSMB to the Board of Directors for its recommendation to the House of Delegates at the Annual  
412 Meeting and perform such other duties as are assigned to it by the Board of Directors. Except for  
413 the Treasurer, no Fellow shall serve on both the Audit and Finance Committees.

414 **SECTION H. NOMINATING COMMITTEE: PROCESS FOR ELECTION**

- 415 1. MEMBERSHIP: The Nominating Committee shall be composed of six Fellows and the Immediate  
416 Past Chair, who shall chair the Committee and serve without vote except in the event of a tie.  
417 At least one elected member of the Nominating Committee shall be a public member. With the  
418 exception of the Immediate Past Chair, no two Committee members shall be from the same  
419 member board and no officer or member of the Board of Directors shall serve on the  
420 Committee. A member of the Nominating Committee may not serve consecutive terms.
- 421 2. ELECTION: At least three Fellows shall be elected at each Annual Meeting of the House of  
422 Delegates by a plurality of votes cast, each to serve for a term of two years. Only an individual  
423 who is a Fellow at the time of the individual’s election shall be eligible for election as a member  
424 of the Nominating Committee. In the event of a tie vote in a runoff election, up to two additional  
425 runoff elections shall be held. Prior to the election, the presiding officer shall cast a sealed  
426 vote, ranking each candidate in a list. The presiding officer’s vote is counted for the candidate  
427 in the runoff election who is highest on the list. The presiding officer’s vote is counted only to  
428 resolve a tie that cannot be decided by the process set forth in this section.

429 3. Members of the Nominating Committee are not eligible for inclusion on the roster of candidates  
 430 for offices and positions to be filled by election at the Annual Meeting of the House of  
 431 Delegates.

432 **SECTION I. SPECIAL COMMITTEES**

433 Special committees may be appointed by the Chair, from time to time, as may be necessary for a  
 434 specific purpose.

435 **SECTION J. REPRESENTATIVES TO OTHER ORGANIZATIONS AND ENTITIES**

436 Appointment of all representatives of the FSMB to other official organizations or entities shall be  
 437 made or nominated by the Chair, with the approval of the Board of Directors, as applicable, and  
 438 shall serve for a term of three years unless the other organization shall specify some other term  
 439 of appointment. Representatives to these organizations shall be Fellows, Honorary Fellows,  
 440 Associate Members or Courtesy Members at the time of their appointment or nomination.

441 **ARTICLE IX. UNITED STATES MEDICAL LICENSING EXAMINATION (USMLE)**

442 **SECTION A.** Except as otherwise set forth in this Article, the composition of committees and  
 443 subcommittees for the USMLE are subject to agreements with and the advice and consent of the  
 444 National Board of Medical Examiners (NBME) and/or the USMLE Composite Committee. The  
 445 Chair, with the approval of the Board of Directors, shall make appointments to the following  
 446 USMLE committees in appropriate numbers and at appropriate times as required by the  
 447 FSMB/NBME Agreement establishing the USMLE and by other agreements as may apply:

- 448 1. USMLE Composite Committee, which shall be responsible for the development, operation and  
 449 maintenance of policies governing the three-step USMLE. The President shall be one of the  
 450 FSMB’s representatives on this Committee.
- 451 2. USMLE Budget Committee, which shall be responsible for the development and monitoring of  
 452 USMLE revenues and expenses, including the establishment of fees. FSMB representatives  
 453 on the Committee will be the Chair, Chair-elect, Treasurer, President and the senior FSMB  
 454 financial staff member.
- 455 3. The USMLE Management Committee shall be responsible for overseeing the design,  
 456 development, scoring and standard setting for the USMLE Step examinations, subject to  
 457 policies established by and reporting to the USMLE Composite Committee. Appointments to

the Management Committee shall be made consistent with the FSMB/NBME Agreement Establishing the USMLE.

**SECTION B.** The President shall provide FSMB advice and consent to the NBME for NBME’s appointments to the USMLE Management Committee and/or any appointments made jointly under the FSMB/NBME Agreement Establishing the USMLE.

**ARTICLE X. POST-LICENSURE ASSESSMENT SYSTEM**

The Post-Licensure Assessment Governing Committee shall be responsible for the development, operation and maintenance of policies governing the Post-Licensure Assessment System (PLAS) established by joint agreement between FSMB and NBME. The Chair, with the approval of the Board of Directors, shall make appointments to the Post-Licensure Assessment Governing Committee and its program committees in appropriate numbers and at appropriate times as required by the FSMB/NBME joint agreement establishing the Post-Licensure Assessment System and by other agreements as may apply.

**ARTICLE XI. FINANCES AND DUES**

**SECTION A. SOURCES OF FUNDS**

Funds necessary for the conduct of the affairs of the FSMB shall be derived from but not be limited to:

1. Annual dues imposed on the Member Medical Boards, Affiliate Members, Courtesy Members and Official Observers;
2. Special assessments established by the House of Delegates;
3. Voluntary contributions, devices, bequests and other gifts;
4. Fees charged for examination services, data base services, credentials verification services and publications.

**SECTION B. ANNUAL DUES, ELIGIBILITY TO SERVE AS A DELEGATE**

The annual dues for Member Medical Boards shall be established, from time to time, by a majority vote of the House of Delegates.

- 484 1. Annual dues for Member Medical Boards shall be the same for all Members regardless of their
- 485 physician populations. Annual dues are due and payable not later than January 1.
- 486 2. Any Member Medical Board whose dues are in default at the time of the Annual Meeting of the
- 487 House of Delegates shall be ineligible to have a seated delegate.

488 **ARTICLE XII. DISCIPLINARY ACTION**

489 **SECTION A. MEMBER**

490 For the purposes of this Article, a member shall be defined as a Member Medical Board, a Fellow,  
491 an Honorary Fellow, an Associate Member, an Affiliate Member, Courtesy Member or Official  
492 Observer.

493 **SECTION B. AUTHORIZATION**

494 The Board of Directors, on behalf of the House of Delegates, may enforce disciplinary measures,  
495 including expulsion, suspension, censure and reprimand, and impose terms and conditions of  
496 probation or such sanctions as it may deem appropriate, for any of the following reasons:

- 497 1. Failure of the member to comply or act in accordance with these Bylaws, the Articles of
- 498 Incorporation of the FSMB, or other duly adopted rules or regulations of the FSMB;
- 499 2. Failure of the member to comply with any contract or agreement between the FSMB and such
- 500 member or with any contract or agreement of the FSMB that binds such member;
- 501 3. Failure of the member to maintain confidentiality or security, or the permitting of conditions that
- 502 allow a breach of confidentiality or security, in any manner dealing with the licensing
- 503 examination process or the confidentiality of FSMB records, including the storage,
- 504 administration, grading or reporting of examinations and information relating to the examination
- 505 process; or
- 506 4. The imposition of a sanction, judgment, disciplinary penalty or other similar action by a Member
- 507 Medical Board that licenses the member or by a state or federal court, or other competent
- 508 tribunal, whether or not related to the practice of medicine and including conduct as a member
- 509 of a Member Medical Board.

510

511

512 **SECTION C. PROCEDURE**

513 Any member alleged to have acted in such manner as to be subject to disciplinary action shall be  
 514 accorded, at a minimum, the procedural protection set forth in the Manual for Disciplinary  
 515 Procedures, which is available from the FSMB upon the written request of any member.

516 **SECTION D. REINSTATEMENT**

517 In the event a member is suspended or expelled from the FSMB, the member may apply to the  
 518 President for reinstatement after one year following final action on expulsion. The President shall  
 519 review the application and the reason for the suspension or expulsion and forward a report to the  
 520 Board. The Board may accept application for reinstatement under such terms and conditions as it  
 521 may deem appropriate, reject the application or request further information from the President.  
 522 The Board's decision to accept or reject an application is final.

523 **ARTICLE XIII. CORPORATE SEAL**

524 The Board of Directors shall adopt a corporate seal that meets the requirements of the state in  
 525 which the FSMB is incorporated.

526 **ARTICLE XIV. ADOPTION AND AMENDMENT OF BYLAWS, EFFECTIVE DATE**

527 **SECTION A. AMENDMENT**

528 These Bylaws may be amended at any annual meeting of the House of Delegates by two-thirds  
 529 of those present and voting. Bylaws changes may be proposed only by the Board of Directors,  
 530 Member Medical Boards or the Bylaws Committee **and its members**. All such proposals must be  
 531 submitted in writing to the Bylaws Committee, in care of the Secretary of the FSMB. The Bylaws  
 532 Committee shall inform the Member Medical Boards of its meeting dates not fewer than **60 sixty**  
 533 days in advance of the meeting. The recommendations of the Bylaws Committee and the full texts  
 534 of all proposed amendments recommended to the Committee shall be sent to each Member  
 535 Medical Board not fewer than **60 sixty** days prior to the Annual Meeting of the House of Delegates  
 536 at which they are to be considered.

537 **SECTION B. EFFECTIVE DATE**

538 These Bylaws and any other subsequent amendments thereto, shall become effective upon their  
 539 adoption, except as otherwise provided herein.

# **Attachment 3**

**2018 FSMB BYLAWS**  
**PROPOSED AMENDMENTS**  
**PROPOSAL #3**

**ARTICLE VIII. STANDING AND SPECIAL COMMITTEES**

**SECTION A. STANDING COMMITTEES**

1. The Standing Committees of the FSMB shall be:
  - a. Audit Committee
  - b. Bylaws Committee
  - c. Editorial Committee
  - d. Education Committee
  - e. Ethics and Professionalism Committee
  - f. Finance Committee
  - g. Nominating Committee
2. **ADDITIONAL STANDING COMMITTEES.** Additional standing committees may be created by resolution of the FSMB and/or amendment to the Bylaws. Chairs and members of all standing committees, with the exception of the Nominating Committee, shall be appointed by the Chair, with the approval of the Board of Directors, for a term of one year, unless otherwise provided for in these Bylaws. Reappointment, unless specifically prohibited, is permissible.
3. **MEMBERSHIP.** Honorary Fellows, Associate Members and Courtesy Members may be appointed by the Chair to serve on a standing committee in addition to the number of committee members called for in the following sections of this chapter. No more than one Honorary Fellow, Associate or Courtesy Member or non-member subject matter expert may be appointed by the Chair to serve in such a capacity on any standing committee unless otherwise provided for in these Bylaws. All committee members shall serve with vote. Honorary Fellows, Associate or Courtesy Members, and non-members appointed to standing committees by the Chair shall serve for a term concurrent with the term of the Chair. No individual shall serve on more than one standing committee except as specified in the Bylaws. With the exception of the Nominating Committee and the Editorial Committee, the Chair and the Chair-elect shall serve, ex-officio, on all committees.
4. **VACANCIES.** In the event a vacancy occurs in an elected position on a standing committee, the Chair, with the approval of the Board of Directors, shall appoint a Fellow to serve on the committee until the next meeting of the House of Delegates, at which time an election will be held to fill the vacant position for the remainder of the unexpired term. In the event a vacancy occurs in an appointed position on a standing committee, the Chair, with the approval of the Board of Directors, shall appoint a Fellow to serve on the committee for the remainder of the unexpired term. In the event

40 the Chairmanship of the Nominating Committee becomes vacant, the FSMB Chair,  
41 with the approval of the FSMB Board of Directors, shall appoint a Past Chair of the  
42 FSMB Board of Directors to serve in that capacity for the remainder of the unexpired  
43 term.

#### 44 **SECTION B. AUDIT COMMITTEE**

45 The Audit Committee shall:

- 46 1. Be composed of five Fellows, three of whom shall be members of the Board of  
47 Directors. The Treasurer of the FSMB shall serve ex-officio without vote. The Chair of  
48 the FSMB shall appoint the Chair of the Audit Committee from one of the three sitting  
49 Board Members.
- 50 2. Ensure that an annual audit of the financial accounts and records of the FSMB is  
51 performed by an independent Certified Public Accounting firm.
- 52 3. Recommend to the Board of Directors the appointment, retention or termination of an  
53 independent auditor or auditors and develop a schedule for periodic solicitation of audit  
54 firms consistent with Board policies and best practices.
- 55 4. Oversee the independent auditors. The independent auditors shall report directly to  
56 the Committee.
- 57 5. Review the audit of the FSMB. Submit such audit and Committee's report to the Board  
58 of Directors.
- 59 6. Report any suggestions to the Board of Directors on fiscal policy to ensure the  
60 continuing financial strength of the FSMB.
- 61 7. When the finalized committee report to the Board of Directors is made, suggestions  
62 and feedback will be forwarded to the Finance Committee.

#### 63 **SECTION C. BYLAWS COMMITTEE**

64 The Bylaws Committee, composed of five Fellows, shall continually assess the Articles of  
65 Incorporation and the Bylaws and shall receive all proposals for amendments thereto. It  
66 shall, from time to time, make recommendations to the House of Delegates for changes,  
67 deletions, modifications and interpretations thereto.

#### 68 **SECTION D. EDITORIAL COMMITTEE**

- 69 1. An Editorial Committee, not to exceed twelve Fellows **and three non-Fellows, at**  
70 **least two of whom shall be subject matter experts**, shall advise the Editor-in-Chief  
71 on editorial policy for the FSMB's official publication, and shall serve as the editorial  
72 board of that publication and otherwise assist the Editor-in-Chief in the performance  
73 of duties as appropriate and necessary. No officer or member of the Board of Directors  
74 shall serve on this Committee.
- 75 2. Service on the Editorial Committee is by nomination and appointment by the FSMB  
76 Chair, subject to approval of the Board of Directors, immediately following the Annual

77 Meeting of the House of Delegates. Candidates are allowed to express their interest  
78 in serving on the Committee through self-nomination. Committee members shall serve  
79 staggered three-year terms and shall be limited to two full terms.

80 3. The Editor-in-Chief shall be elected by the Editorial Committee to a three-year term  
81 beginning on the date of the annual Editorial Committee meeting, with the Editor-in-  
82 Chief's term on the Editorial Committee being automatically extended to allow the  
83 Editor-in-chief to serve for three years. A member of the Editorial Committee whose  
84 term is expiring shall continue to serve until the member's replacement meets at the  
85 next annual Editorial Committee meeting.

86 4. The Editorial Committee will elect its Chair, who will serve as the Editor-in-Chief of the  
87 *Journal of Medical Regulation*. The Editor-in-Chief will serve without compensation  
88 and will coordinate decisions on the *Journal* content, among other duties to be  
89 determined by the Bylaws Committee.

#### 90 **SECTION E. EDUCATION COMMITTEE**

91 The Education Committee shall be composed of eight Fellows, to include the Chair as  
92 chair, the Immediate Past Chair and the Chair-elect. The Committee shall be responsible  
93 for assisting in the development of educational programs for the FSMB.

#### 94 **SECTION F. ETHICS AND PROFESSIONALISM COMMITTEE**

95 The Ethics and Professionalism Committee shall be composed of up to five Fellows and  
96 up to two subject matter experts. The Ethics and Professionalism Committee shall  
97 address ethical and professional issues pertinent to medical regulation.

#### 98 **SECTION G. FINANCE COMMITTEE**

99 The Finance Committee shall be composed of five Fellows, to include the Treasurer as  
100 Chair. The Finance Committee shall review the financial condition of the FSMB, review  
101 and evaluate the costs of the activities and programs to be undertaken in the  
102 forthcoming year, present a budget for the FSMB to the Board of Directors for its  
103 recommendation to the House of Delegates at the Annual Meeting and perform such  
104 other duties as are assigned to it by the Board of Directors. Except for the Treasurer, no  
105 Fellow shall serve on both the Audit and Finance Committees.

#### 106 **SECTION H. NOMINATING COMMITTEE: PROCESS FOR ELECTION**

107 1. MEMBERSHIP: The Nominating Committee shall be composed of six Fellows and the  
108 Immediate Past Chair, who shall chair the Committee and serve without vote except  
109 in the event of a tie. At least one elected member of the Nominating Committee shall  
110 be a public member. With the exception of the Immediate Past Chair, no two  
111 Committee members shall be from the same member board and no officer or member  
112 of the Board of Directors shall serve on the Committee. A member of the Nominating  
113 Committee may not serve consecutive terms.

- 114 2. ELECTION: At least three Fellows shall be elected at each Annual Meeting of the House  
115 of Delegates by a plurality of votes cast, each to serve for a term of two years. Only  
116 an individual who is a Fellow at the time of the individual's election shall be eligible for  
117 election as a member of the Nominating Committee. In the event of a tie vote in a  
118 runoff election, up to two additional runoff elections shall be held. Prior to the election,  
119 the presiding officer shall cast a sealed vote, ranking each candidate in a list. The  
120 presiding officer's vote is counted for the candidate in the runoff election who is highest  
121 on the list. The presiding officer's vote is counted only to resolve a tie that cannot be  
122 decided by the process set forth in this section.
- 123 3. Members of the Nominating Committee are not eligible for inclusion on the roster of  
124 candidates for offices and positions to be filled by election at the Annual Meeting of  
125 the House of Delegates.

126 **SECTION I. SPECIAL COMMITTEES**

127 Special committees may be appointed by the Chair, from time to time, as may be  
128 necessary for a specific purpose.

129 **SECTION J. REPRESENTATIVES TO OTHER ORGANIZATIONS AND ENTITIES**

130 Appointment of all representatives of the FSMB to other official organizations or entities  
131 shall be made or nominated by the Chair, with the approval of the Board of Directors, as  
132 applicable, and shall serve for a term of three years unless the other organization shall  
133 specify some other term of appointment. Representatives to these organizations shall be  
134 Fellows, Honorary Fellows, Associate Members or Courtesy Members at the time of their  
135 appointment or nomination.

# **Attachment 4**

**2018 FSMB BYLAWS  
PROPOSED AMENDMENT  
PROPOSAL #4**

**ARTICLE IV. BOARD OF DIRECTORS**

**SECTION A. MEMBERSHIP AND TERMS**

1. MEMBERSHIP: The Board of Directors shall be composed of the Officers, the Immediate Past Chair, nine Directors-at-Large and two Associate Members. At least two members of the Board, who are not Associate Members, shall be ~~non-physicians, at least one of whom shall be a~~ public/consumer members.

TN Board Comment:

This simple modification of the FSMB Bylaws makes clear that the Public/Consumer members' participation and perspective on the Board of Directors is valued and aligned with the member medical boards of the FSMB.

It should be noted that non-physician members can be elected to the Board of Directors if they are fellows of the FSMB. This proposed change to the Bylaws would not alter that status.

There are nine Directors-at-Large and two Associate Members on the FSMB Board of Directors in addition to the Officers of the Board of Directors and the Immediate Past Chair. The Secretary (President) of the Board of Directors is ex officio and does not vote.

**Federation of State Medical Boards**  
**Report of the Nominating Committee**  
**January 19, 2018**

The Nominating Committee met on Friday, January 19, 2018 in Irving, Texas at 9:00 am CST. FSMB Immediate Past Chair Dr. Arthur Hengerer serves as Chair of the Committee. Other members of the Committee include Dr. Howard (Joey) Falgout, Dr. Jone Geimer-Flanders, Dr. Marilyn Heine, Dr. Stuart Mackler, Dr. Michelle Terry and Carmela Torrelli. Providing staff support were FSMB President and CEO Dr. Humayun Chaudhry, Director of Leadership Services Pat McCarty, and Governance Support Associate Pam Huffman.

Dr. Hengerer expressed his sincere appreciation for the Committee's dedication and emphasized the importance of their work in selecting highly qualified candidates for the elected office positions.

The Committee reviewed all submitted nomination materials; considered the results of the one-on-one interviews between the Committee members and nominees; and discussed the importance of selecting candidates who fulfill the qualifications for FSMB leadership positions as outlined in the Committee's charge. The Committee also shared ideas for strengthening the process of finding good candidates in the future. After thoughtful and careful deliberation throughout the vetting process, the Nominating Committee unanimously approved the following roster of candidates:

**Chair-elect** – 1 fellow, to be elected for three years; a one-year term as chair-elect; a one year term as chair; and a one-year term as immediate past chair

Assists the chair in the discharge of the chair's duties; and performs the duties of the chair at the chair's request or, in the event of the chair's temporary absence or incapacitation, at the request of the Board of Directors.

**Scott A. Steingard, DO – Arizona Osteopathic**

With only one candidate for chair-elect, Dr. Steingard will be elected by acclamation; his current term on the FSMB Board of Directors does not expire until 2019, therefore his election as chair-elect will result in a partial term of one year to be filled.

**Treasurer** – 1 fellow, to be elected for a three-year term

The Treasurer shall perform the duties customary to that office and shall perform such other duties as the Bylaws and custom and parliamentary usage may require or as the Board of Directors shall deem appropriate; serves as chair of the Finance Committee and as an ex officio member of the Audit Committee.

**Jerry G. Landau, JD – Arizona Osteopathic**

With only one candidate for treasurer, Mr. Landau will be elected by acclamation; his current term as a director-at-large on the FSMB Board of Directors expires in May 2018 and is one of the full terms that will need to be filled.

**Board of Directors** – 4 fellows; three to be elected for a three-year term each; one to be elected for a one-year term.

Control and administration of the corporation is vested in the Board of Directors, which is the fiscal agent of the corporation; the Board acts for the FSMB between Annual Meetings.

**Mohammed A. Arsiwala, MD – Michigan Medical**

**Anna Z. Hayden, DO – Florida Osteopathic**

**Shawn P. Parker, JD, MPA\* – North Carolina**

**Anita M. Steinbergh, DO – Ohio**

**Sarvam P. TerKonda, MD – Florida Medical**

**Joseph R. Willett, DO - Minnesota**

\*In accordance with the FSMB bylaws, “*At least two members of the Board, who are not Associate Members, shall be non-physicians, at least one of whom shall be a public/consumer member.*” With Mr. Landau’s pending election as treasurer and the continued service of another public member on the Board, this bylaws requirement will be fulfilled. Therefore, there will be no need to address the public member candidacy separately. The public member and physician candidates will be included on the same slate.

One candidate will need to be elected to fill Mr. Landau’s expired term (a 3-year term). Dr. Hayden’s current term as director-at-large on the Board expires in May 2018 resulting in a 2<sup>nd</sup> full term to be filled. The term of another board member who is not eligible for re-election also expires in 2018 resulting in a 3<sup>rd</sup> full term to be filled. A fourth candidate will need to be elected to serve a partial term of 1 year due to Dr. Steingard’s pending election as chair-elect.

**Nominating Committee** – 3 fellows, each to be elected for a two-year term

Committee members select a roster of nominees for each of the elected positions to be filled at the annual business meeting of the House of Delegates.

**Nathaniel B. Berg, MD – Guam [Dr. Berg has withdrawn his nomination]\***

**Ahmed D. Faheem, MD – West Virginia Medical**

**Robert P. Giacalone, RPh, JD – Ohio**

**Kenneth J. Walker, MD – Virginia**

*\*In accordance with the FSMB bylaws, “At least one elected member of the Nominating Committee shall be a public member.”* The term of the one public member currently on the Nominating Committee will expire in May 2018; therefore the 2018 House of Delegates will be required to elect at least one public member. With only three candidates for the Nominating Committee, including the requisite public member, the three candidates will be elected by acclamation.

No two Nominating Committee members are to be from the same member board. Continuing members of the Committee are from Alabama, Pennsylvania Medical and Washington Medical.

Respectfully submitted,

Arthur S. Hengerer, MD, FACS  
Chair, Nominating Committee

## AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request:		2) Date When Request Submitted:  3/7/2018 <small>Items will be considered late if submitted after 12:00 p.m. on the deadline date which is 8 business days before the meeting</small>	
3) Name of Board, Committee, Council, Sections:  Medical Examining Board			
4) Meeting Date:  3/21/2018	5) Attachments: x Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page?  Re-Entry to Practice	
7) Place Item in: x Open Session <input type="checkbox"/> Closed Session	8) Is an appearance before the Board being scheduled?  <input type="checkbox"/> Yes ( <a href="#">Fill out Board Appearance Request</a> ) xNo	9) Name of Case Advisor(s), if required:	
10) Describe the issue and action that should be addressed:  Review research relating to re-entry to practice, including attachments and the following references:  <a href="http://physician-reentry.org/resources/reentry-physicians-reading-list/">http://physician-reentry.org/resources/reentry-physicians-reading-list/</a>  <a href="https://well.blogs.nytimes.com/2013/01/10/when-the-doctor-returns-to-doctoring/?_php=true&amp;_type=blogs&amp;_r=0">https://well.blogs.nytimes.com/2013/01/10/when-the-doctor-returns-to-doctoring/?_php=true&amp;_type=blogs&amp;_r=0</a>			
11) Authorization			
Signature of person making this request			Date
Supervisor (if required)			Date
Executive Director signature (indicates approval to add post agenda deadline item to agenda) Date			
Directions for including supporting documents: 1. This form should be attached to any documents submitted to the agenda. 2. Post Agenda Deadline items must be authorized by a Supervisor and the Policy Development Executive Director. 3. If necessary, provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.			



# Facilitating Physician Reentry to Practice: Perceived Effects of Deployments on US Army Pediatricians' Clinical and Procedural Skills

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**Introduction:** US Army pediatricians regularly deploy for 6 to 12 months or longer and many are deployed multiple times during their career. Prolonged breaks in pediatric clinical practice may result in skill degradation, requiring a physician reentry process to prepare pediatricians to return to clinical practice. This study sought to identify which specific pediatric clinical skills were felt to be most affected by deployment.

**Methods:** Army pediatricians on active duty between January 2012 and March 2012 were surveyed via e-mail to determine their comfort level and experience with clinical encounters and procedural skills prior to and after military deployment.

**Results:** Eighty-three pediatricians were eligible, and 75 responded (90% response rate). Of those received, 65 surveys (78%) were complete and included in the statistical analysis. Over half (54%) of the respondents were deployed longer than 6 months, and 32% were deployed for 12 months or longer. The largest changes in reported comfort were seen in neonatal, pediatric, and adolescent acute care and neonatal routine care, including neonatal and pediatric procedures. There was a significant negative correlation ( $r = .64$ ;  $p = .003$ ) between provider's reported exposure to neonatal and pediatric clinical encounters during deployment and provider's comfort with those clinical encounters after deployment.

**Discussion:** US Army pediatricians are required to deploy for extended periods of time and have limited opportunities to practice the full range of their pediatric skills. This break in clinical practice is associated with a significant decline in perceived comfort with both routine and acute pediatric care.

**Key Words:** physician reentry, medical/clinical speciality, career transitions, deployment, clinical skills, procedural skills, refresher training, pediatrics

## Introduction

The US military has been involved in continuous combat operations for more than a decade. US Army pediatricians are commonly deployed during times of war.<sup>1,2</sup> Over the past

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decade, approximately 40% to 60% of all US Army pediatric residency graduates have deployed to combat operations within 3 years after graduation.<sup>3</sup> Since 44.6% of enlisted soldiers and 12.7% of officers are 25 years of age or younger,<sup>4</sup> US Army pediatricians have the opportunity to routinely practice adolescent medicine; however, the limited opportunities to provide pediatric and neonatal care<sup>2</sup> may result in a degradation of pediatric and neonatal skills. A prior survey of US military medical providers and surgeons found a significant perceived degradation in both the clinical and surgical skills after military deployment, and the degradation was correlated with the length of time deployed.<sup>5</sup> Developing postdeployment physician reentry programs is an active area of exploration for the US Army Medical Department.

The challenges facing physicians upon reentry to clinical practices was first addressed in 2002 by the American Medical Association (AMA) National Task Force on Reentry into Clinical Medicine for Health Professionals.<sup>6</sup> Physician reentry is defined by the AMA 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; distinct from remediation or retraining.”<sup>7</sup> Clinical inactivity has previously been attributed to leaving clinical practice for personal reasons, such as raising children or caring for ill family members, or changes in career tracks to enter administration, research, or industry.<sup>8</sup> Freed et al concluded after telephone interviews with representatives of all 64 state allopathic and osteopathic medical licensing boards that state medical board policies do not address physician clinical activity upon license renewal and highlighted potential implications for safe patient care.<sup>9</sup> Multiple organizations have since raised the issue of physician reentry into clinical practice and have included “military service” as a reason for physician reentry,<sup>10–12</sup> but the requirements for physicians to undergo a reentry process varies by state and ranges from 1 to 5 years of clinical inactivity.<sup>13</sup> There is little comprehensive information about the decay rate of specific areas of knowledge and skill.

In 2007, at the request of the US Army Surgeon General’s Office, the Central Simulation Committee (CSC) conducted a survey of all previously deployed US Army physicians to quantify the issue of potential skill degradation.<sup>5</sup> A total of 673 providers responded. Responses indicated that nearly 50% of providers did not practice in their primary specialty while they were deployed. The physicians surveyed felt that their primary specialty skills were significantly worse after returning from deployment. When asked how long it took them to get back to their predeployment surgical performance level, 30% of physicians in surgical specialties said it took at least 6 months, and 40% of physicians in medical specialties said it took 6 months or longer. In that study there was a statistically significant association between length of deployment and the time it took for providers to feel they were back to their baseline level of performance, with longer deployments being associated with longer delays in returning to baseline performance. The current study expands on these findings by determining perceived clinical skill changes specifically for US Army pediatricians, and investigates in detail which specific pediatric clinical skills were felt to be most affected by deployment.

As part of the Redeployment Specialty Skills Matrix Survey conducted by the US Army Healthcare System’s CSC, the authors conducted the following study in order to determine what pediatric-specific procedures and clinical encounters US Army pediatricians felt were most affected by deployment. The objectives of this study were to (1) gather general data about the pediatric-specific clinical encounters and procedural skills US Army pediatricians felt were most affected by deployment, and (2) identify areas in which US Army pediatricians would benefit from postdeployment reentry training. Our hypothesis was that those clinical encounters and procedural skills practiced least during deploy-

ment would be perceived to be the most affected, and would be the optimal targets for postdeployment reentry training.

## Methods

The study utilized a cross-sectional cohort survey design. Eligible participants included Army pediatricians on active duty between January 2012 and March 2012. The study was included as part of a larger Redeployment Specialty Skills Matrix Survey study conducted by the CSC. The CSC provides centralized oversight and support of graduate medical education simulation-based training for the U.S. Army Medical Department, and provides simulation-based reentry training for physicians returning from the wars in Iraq and Afghanistan.<sup>14</sup> The 12 specialties currently covered by the CSC are Anesthesia, Emergency Medicine, Family Medicine, General Surgery, Obstetrics/Gynecology, Pathology, Internal Medicine, Ophthalmology, Orthopedics, Radiology, Urology, and Pediatrics.

### Survey Design

The Redeployment Specialty Skills Matrix Survey was developed by the Specialty Advisors to the CSC. Specialty Advisors were 2 board-certified pediatricians with subject matter expertise in simulation-based medical education. For the pediatric portion of the survey, the Pediatric Specialty Advisors to the CSC were asked to identify the most common clinical encounters and procedural skills practiced by US Army pediatricians when not deployed. Based on this list of clinical encounters and procedures, a set of questions was developed to determine the comfort level with each clinical encounter type and procedural skill, as well as overall comfort level with the practice of pediatrics prior to and after deployment.

Pediatricians were asked a series of 3 questions for 29 clinical encounters/procedures. The first was “Please rate how comfortable you were in managing/performing the following clinical encounters/procedures prior to your deployment.” The second was “Please rate how comfortable you were in managing/performing the following clinical encounters/procedures immediately after you returned from deployment when you resumed clinical duties.” And, finally, “Please note how often you saw/performed the following clinical encounters/procedures during your most recent deployment.” Questions utilized a 5-point Likert scale: completely comfortable (5), somewhat comfortable (4), neutral (3), somewhat uncomfortable (2), not comfortable at all (1). “Not applicable” responses were also included where deemed appropriate. The survey also included questions on the types of pediatric clinical encounters and procedural skills experienced during deployment. In addition, the survey asked for demographic information on the number of times the provider had been deployed, length of the most recent deployment, the capacity in which the provider was deployed,

and if the provider was offered postdeployment reentry training. Validity of the survey was examined using several lines of evidence, including content validity, responses process validity, and consequence validity, as described by Downing.<sup>15</sup> Content validity was assured by the development of survey questions by pediatrics subject matter experts. Response process, defined as evidence of data integrity such that sources of error associated with the test administration are controlled as much as possible, was provided by the online administration of the survey in an easy-to-use multiple-choice format. The consequential aspect of validity refers to the impact (positive or negative) on the participants. As the survey was voluntary and anonymous, there were no inherent risks to the survey participants, and thus no clear threats to the consequence validity of the survey.

### Survey Distribution

The Redeployment Specialty Skills Matrix Survey was distributed to 2158 deployment-eligible active-duty US Army Medical Corps physicians and surgeons in the US Army Medical Command via e-mail. This group included 83 general and subspecialty pediatricians. The e-mail survey included an invitation to participate in the survey along with a link to the anonymous online survey portal. An additional e-mail reminder was sent out approximately 1 month after the initial e-mail. The survey was available from January 11, 2012, to March 9, 2012. The average survey completion time was approximately 10 minutes. All surveys initiated and received back were reviewed for completion. Surveys were considered complete if answers were provided to all questions.

### Statistical Analysis

Descriptive statistics were used to analyze demographic data of times deployed during military career, number of months of last deployment, location of last deployment, total months deployed in past 10 years, and time to return to clinical duties after deployment. In order to determine the most clinically significant changes in perceived comfort level, McNemar's test was used to analyze predeployment versus postdeployment changes in comfort levels from 4 or 5 (somewhat comfortable = 4, completely comfortable = 5) to anything less (neutral = 3, somewhat uncomfortable = 2, very uncomfortable = 1). Pearson's product moment correlation was used to determine the correlation between provider's exposure to clinical encounters and procedures during deployment with difference in provider comfort with the encounters and procedures prior to, and after, deployment. Statistical analysis was conducted using SPSS (IBM) software. A *p* value of < .05 was considered statistically significant.

TABLE 1. Demographic Data

Category	<i>n</i> (%)	Mean (S.D)*
<b>Times Deployed During Military Career</b>		1.43 (.77)
1	45 (69)	
2	14 (22)	
3	5 (8)	
> 5	1 (2)	
<b>Number of Months Last Deployment</b>		2.67 (.79)
1–3	2 (3)	
4–6	28 (43)	
7–12	24 (37)	
12–15	11 (17)	
<b>Location of Last Deployment</b>		
Iraq	40 (62)	
Afghanistan	22 (34)	
Other	1 (2)	
<b>Total Months Deployed in Past 10 years</b>		3.22 (1.14)
1–3	1 (2)	
4–6	17 (26)	
7–12	20 (40)	
12–15	13 (20)	
16–24	4 (6)	
>24 months	4 (6)	
<b>Return to clinical duties after deployment (# of days)</b>		3.68 (1.13)
<7	1 (2)	
8–14	11 (17)	
15–21	14 (22)	
22–30	18 (28)	
>30	19 (29)	

\*Mean and Standard Derivations of the response categories.

## Results

The Redeployment Specialty Skills Matrix Survey was completed by 888 of the 2158 US Army providers surveyed, resulting in a survey response rate of 41%. Seventy-five of the 83 eligible pediatricians completed the survey, resulting in a 90% survey response rate. Of the 75 surveys received from pediatricians, only 65 surveys (78%) were complete and included in the statistical analysis reported here.

TABLE 1 provides demographic data on pediatricians who completed the survey. The majority of pediatricians

TABLE 2. Changes in Comfort with Pediatric Clinical Encounters and Exposure to Pediatric Clinical Encounters During Deployment

Clinical Encounters	Comfort <sup>†</sup>	Comfort	P*	Encountered During Deployment n (%)**
	Pre-Deployment n (%)	Post-Deployment n (%)		
<b>Neonatal Routine Care</b>				
Basic Newborn Care	60 (94)	55 (86)	.18	8 (12)
Neonatal Jaundice	60 (95)	52 (83)	.02	3 (5)
Febrile Illness in Infant	60 (97)	51 (82)	.01	11 (17)
<b>Neonatal Acute Care</b>				
Neonatal Resuscitation	60 (94)	40 (63)	<0.001	6 (9)
Preterm and Critically Ill Newborn Stabilization	51 (81)	34 (54)	<0.001	4 (6)
Neonatal Hypoglycemia	55 (86)	39 (61)	<0.001	2 (3)
Evaluation of Cyanotic Newborn	58 (91)	41 (64)	<0.001	2 (3)
<b>Pediatric and Adolescent Routine Care</b>				
Otitis Media Diagnosis and Management	61 (97)	59 (94)	.63	38 (59)
Adolescent Well Visit	57 (89)	50 (78)	.04	14 (22)
Asthma	60 (94)	56 (88)	.22	49 (76)
ADHD <sup>+</sup> Evaluation	53 (83)	47 (73)	.07	12 (19)
Upper Respiratory Tract Infections	61 (97)	55 (87)	.07	44 (69)
Well-Child Checks	60 (95)	52 (83)	.02	8 (12)
Bronchiolitis	62 (97)	54 (84)	.02	8 (12)
Developmental Screening	57 (89)	40 (63)	<0.001	3 (5)
<b>Pediatric and Adolescent Acute Care</b>				
Sepsis/Meningitis	59 (94)	47 (75)	.004	18 (28)
Management of Pediatric Airway Emergencies	58 (91)	46 (72)	.002	15 (23)
Pediatric Resuscitation	59 (94)	46 (73)	<0.001	6 (9)
Pediatric Seizure	56 (89)	42 (67)	<0.001	10 (15)

†Respondents who indicated they felt either ‘Somewhat Comfortable’ or ‘Completely Comfortable’

\*Change from ‘Somewhat Comfortable’ or ‘Completely Comfortable’ Pre- versus Post-Deployment

\*\*Number of providers reporting any exposure to the clinical encounter type during deployment

+ADHD, attention deficit hyperactivity disorder

(69%) reported being deployed only once in the previous 10 years, while 32% reported deployment 2 or more times. The majority (62%) of pediatricians were deployed to Iraq. The most commonly reported total number of months deployed in the previous 10 years was 7 to 12 months. Over half (54%) of the respondents were deployed longer than 6 months during their most recent deployment, and 32% were deployed 12 months or longer. Upon return from deployment, the majority (79%) of Army pediatricians reported taking 3 weeks or longer to return to clinical duties.

TABLE 2 presents data on comfort levels with different types of clinical encounters prior to and after return from deployment, and self-reported frequency of the clinical encounter types experienced during deployment. The largest changes in reported comfort were seen in neonatal acute care, including neonatal resuscitation and newborn stabilization ( $p < .001$ ). Significant changes in comfort were also seen in neonatal routine care, including neonatal jaundice ( $p = .02$ ) and febrile illness ( $p = .01$ ). Changes in comfort with pediatric and adolescent acute care were most significant for

TABLE 3. Changes in Comfort with Pediatric Procedures and Performance of Pediatric Procedures During Deployment

Procedures	Comfort <sup>†</sup> Pre-Deployment <i>n</i> (%)	Comfort Post- Deployment <i>n</i> (%)	P*	Performed During Deployment <i>n</i> (%)**
<b>Neonatal Procedures</b>				
Umbilical Venous/Arterial Access	46 (74)	29 (47)	<.001	2 (3)
Neonatal Arterial Stick	57 (89)	40 (63)	<.001	4 (6)
Neonatal Circumcision	54 (84)	37 (58)	<.001	3 (5)
Intubation for Meconium Stained Fluid	57 (89)	37 (58)	<.001	3 (5)
<b>Neonatal and Pediatric Procedures</b>				
Pediatric/Neonatal Venipuncture	53 (85)	43 (69)	.013	12 (19)
Pediatric/Neonatal Intravenous Line Placement	55 (89)	40 (65)	<.001	17 (26)
Pediatric/Neonatal Lumbar Puncture	59 (94)	41 (65)	<.001	6 (9)
<b>Pediatric and Adolescent Procedures</b>				
Gynecologic Exam	40 (63)	39 (61)	1.0	34 (53)
Pediatric Nasogastric Tube Placement	54 (86)	43 (68)	.007	6 (9)
Pediatric Bladder Catheterization	51 (81)	37 (59)	.001	5 (8)

<sup>†</sup>Respondents who indicated they felt either 'Somewhat Comfortable' or 'Completely Comfortable'

\*Change from 'Somewhat Comfortable' or 'Completely Comfortable' Pre versus Post Deployment

\*\*Number of providers reporting *any* performance of the procedure during deployment

pediatric resuscitation and pediatric seizure ( $p < .001$ ). Changes in pediatric and adolescent routine care were most notable for developmental screening ( $p < .001$ ). There was a significant negative correlation ( $r = .64$ ;  $p = .003$ ) between provider's reported exposure to neonatal and pediatric clinical encounters during deployment and provider's change in comfort with those clinical encounters/procedures prior to and after deployment. Pediatricians did not report a significant change in comfort with basic newborn care, otitis media diagnosis and management, asthma, attention deficit hyperactivity disorder (ADHD), and upper respiratory tract infections (URIs). Of those encounters without significant change in comfort, over half of the providers were exposed to asthma, URIs, and otitis media during their deployment.

TABLE 3 presents data on comfort levels with different neonatal and pediatric procedures prior to and after return from deployment and self-reported frequency of performing the procedures during deployment. The largest changes in reported comfort were in neonatal procedures including umbilical venous/arterial access, neonatal arterial stick, neona-

tal circumcision, and intubation for meconium-stained fluid ( $p < .001$ ). Significant changes in comfort were also seen in other neonatal, pediatric, and adolescent procedures, most notably pediatric/neonatal intravenous line placement and pediatric/neonatal lumbar puncture ( $p = .01$ ). There was no change in comfort with gynecological exams prior to and after deployment and this procedure was the most commonly performed during deployment. There was a significant negative correlation ( $r = -.861$ ;  $p = .001$ ) between provider's reported exposure to procedures during deployment and provider's change in comfort with those procedures prior to and after deployment.

## Discussion

We conducted this study in order to determine what pediatric-specific procedures and clinical encounters US Army pediatricians felt were most affected by deployment. Our objectives were to gather data about the pediatric-specific clinical encounters of US Army pediatricians and which procedural

skills they felt were most affected by deployment. We sought this information to identify areas in which US Army pediatricians would benefit most from reentry training.

Not all pediatricians responded that they were “somewhat comfortable” or “completely comfortable” with the clinical encounters and procedures in TABLES 2 and 3 prior to deployment. Since the survey was sent to both general and subspecialty pediatricians, it was not expected that every respondent would indicate predeployment comfort with routine and acute neonatal, pediatric, and adolescent care. For example, a general pediatrician who provides routine pediatric care in a general pediatric clinic may not feel comfortable placing umbilical venous lines. Similarly, a neonatologist may not feel comfortable completing an ADHD evaluation. Rather, we were interested in identifying a significant change in the level of provider comfort with specific types of encounters and procedures postdeployment compared to their own comfort level predeployment, with each provider serving as their own control.

Our results show that US Army pediatricians experience a significant decrease in comfort with neonatal and pediatric clinical encounters and procedural skills following deployment. The most significant deteriorations appear to be in the areas of acute care for neonatal, pediatric, and adolescent patients as well as neonatal and pediatric procedures. The decreased level of provider comfort with neonatal and pediatric clinical encounters and procedures upon return from deployment was strongly correlated with a lack of exposure to those clinical encounters and procedures during deployment.

We know that clinical and procedural skills often degrade with time if not practiced. The term *deskilling* has been applied to this gradual loss of skills through lack of practice.<sup>16</sup> Kovács et al provided 1 example of deskilling when they demonstrated a decline in airway management skills as early as 16 weeks after training a novice group of students who were not provided feedback or the opportunity to practice.<sup>17</sup> This decay curve was decreased by providing the ability to practice the skill periodically.<sup>17</sup> For practitioners with significant prior experience and practice with a clinical skill, the degradation may be much slower. Since the majority of US Army pediatricians are deployed within 3 years after graduating residency,<sup>3</sup> clinical skill degradation may be more rapid. However, the precise degradation curves for clinical and procedural skills are unknown.

For practitioners who do not have the opportunity to participate in clinical practice on a regular basis, simulation-based training may be a feasible method to allow needed practice. Simulation-based training has been advocated as a means to augment neonatal and pediatric resuscitation training for pediatric residents.<sup>18–20</sup> In a study by Nadel et al,<sup>21</sup> pediatric residents who participated in a structured resuscitation curriculum that included 3 simulated mock codes had better performance compared to a residents who

did not receive the simulation training. Donoghue et al<sup>19</sup> reported that high-fidelity simulation improved cognitive performance by pediatric residents in pediatric advanced life support (PALS) and recommended studies to investigate skill and knowledge decays over time. Sawyer et al showed that participation in simulation-based deliberate practice in neonatal resuscitation was effective at improving pediatric resident neonatal resuscitation program (NRP) skills.<sup>22</sup>

The critical role that US Army pediatricians serve in armed conflicts has been elegantly described by Burnett and Callahan.<sup>2</sup> Whether pediatricians should be deployed in times of war is not the question; rather, the issue is how to maintain skills during deployment and ensure successful physician reentry upon return. Since 2007 the CSC has been working to develop simulation-based postdeployment training for physicians returning from the wars in Iraq and Afghanistan.<sup>23</sup> While it is not mandatory that this simulation-based reentry training occur after deployment, the US Army Office of the Surgeon General Policy Memo 12-043 specifies that Army Medical Treatment Facility commanders are responsible for ensuring that all physicians who are deployed for more than 60 days are assessed for their need of reentry training and provided the opportunity for appropriate reentry training.<sup>24</sup> US Army physicians undergo a standardized credentialing process that involves evaluation of peer-review assessments of patient care and review of board certification, continuing medical education, current medical licensure, peer and supervisory recommendation letters, and life support training every 2 years for experienced physicians and more frequently for providers who are just entering practice. Upon returning from deployment, physicians who have not practiced their specialty-specific skills will require a specific plan to address reentry training during the credentialing process. The policy further states that physicians and clinical supervisors, in collaboration with the CSC Specialty Consultant, are to identify specific individual reentry training requirements for procedures and clinical care prior to independent performance after deployment. Once the specific individual training requirements are determined, various physician reentry training opportunities are available including:

- Cognitive, self-paced continuing medical education courses, available through professional societies and online medical sites.
- On-the-job refresher training under enhanced supervision.
- Simulation-based training available through the CSC at various training medical treatment facilities.
- Short courses or conferences, available through professional organizations and societies, including advanced life-support courses such as NRP and PALS.

Participation in these reentry training activities are to be documented through the local medical credentials office.

This study has important implications for civilian pediatric practitioners who take long breaks from clinical practice, for reasons such as family and sabbaticals. Civilian pediatricians who leave their primary area of practice for extended periods of time are expected to experience deskilling.<sup>6</sup> Developing methods in the civilian community to provide reentry training, similar to those which have been developed by the Army, may prove beneficial. The Physician Reentry Into the Workforce Project<sup>25</sup> provides some useful guidance on this process, particularly, making a timeline for the planned departure from pediatric clinical practice, reevaluating the timeline at regular intervals, making a plan for ongoing learning while away from clinical duties, staying current with medical knowledge, and integrating skills refresher training into the return “timeline” to allow ample time for preparation to return to clinical practice.

This study has some limitations. The results reported here are self-reports of perceived comfort with clinical encounters and medical procedures. The use of provider self-reports of comfort was chosen for this study, as it is a feasible means of assessing providers’ own perceptions of clinical competency. However, we acknowledge that the relationship of self-reported comfort level with the actual clinical competency of a physician has not been fully defined. Exposure to clinical cases and procedures during deployment are also self-reported and are thus at risk for recall bias. Additionally, the majority of physicians surveyed reported an average deployment length of only 4 to 6 months. Therefore, the results of this survey may not adequately reflect the impact of longer deployments on clinical skill retention. Finally, the survey did not ask respondents if they were deployed at the time of the survey or how long since they were deployed. Physicians who were recently deployed or returning may perceive their proficiency differently compared to physicians who had returned from deployment several years prior to taking the survey.

Valid assessment tools are required to identify individual physician training needs so that reentry programs can be developed. Simulation-based mastery learning (SBML) is a method of competency-based training that has been used to evaluate retention of performance knowledge and skills over time,<sup>23,26–28</sup> but this requires an initial evaluation of baseline performance with clear mastery-level performance standards and continued practice until the mastery-level standard is reached. This method of training provides a standardized baseline and allows assessment of deterioration of knowledge and skills over time. Although this training method has been used to improve performance of some procedural skills, it is time intensive and not routinely utilized. This is an area that deserves attention in future research.

In conclusion, US Army pediatricians are required to deploy for extended periods of time and have limited opportunities to practice the full range of their pediatric skills. This

gap in clinical practice is associated with a significant decline in perceived comfort with both routine and acute pediatric care. Simulation-based training opportunities could be expanded to assist pediatricians in maintaining their clinical skills during deployment and refreshing them upon return, better preparing pediatricians for reentry into clinical pediatric practice. The same refresher training used in the US Army for pediatricians returning from deployment could be used to assist civilian pediatricians in reestablishing clinical skills upon return to work after long breaks in practice.

### Disclaimer

The views expressed in this article are those of the author(s) and do not reflect the official policy or position of the Department of the Army, Department of Defense, or the US government.

### Lessons for Practice

- US Army pediatricians are required to deploy for extended periods of time and have limited opportunities to practice the full range of their pediatric skills.
- US Army pediatricians experience a significant decrease in comfort with neonatal and pediatric clinical encounters and procedural skills following deployment.
- Planning for physician workforce reentry should be initiated prior to deployment, reevaluated at regular intervals, include a plan for ongoing learning while away, and integration of skills refresher training upon return to clinical practice in a nondeployment setting.
- Valid assessment tools are required to identify individual physician training needs to improve reentry program development.

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North Pacific Surgical Association

# Perceived effects of deployments on surgeon and physician skills in the US Army Medical Department

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## KEYWORDS:

Skills degradation;  
Military deployment;  
Refresher training

## Abstract

**BACKGROUND:** The military health care system is unique in that almost every physician deploys for  $\geq 6$  months to a combat or far-forward setting. The aim of this study was to determine the perceived changes in clinical skills in this deployed population.

**METHODS:** A survey was sent out to all specialty consultants to the Army Surgeon General to query active duty staff physicians in their specialty areas who have deployment experience in August 2007. Questions concerning specialty, length of deployment, perceived changes in skills, skill use while deployed, and time to get back to baseline clinically after deployment were asked.

**RESULTS:** Surveys were sent to approximately 1,500 physicians, of which 673 were usable, for a 45% response rate. More than 70% of respondents were deployed for  $>6$  months. Fifty-nine percent reported that they were used in their specialties  $<40\%$  of the time deployed. Surgeons rated surgical skills before and after deployment as  $6.0 \pm 1.0$  and  $4.0 \pm 1.5$ , respectively (on a 7-point, Likert-type scale ranging from 1 = worst to 7 = best;  $P = .001$ ). Most felt that the time needed to get back to predeployment skill levels was 1 to 6 months.

**CONCLUSIONS:** There was significant perceived degradation in both the surgical and clinical skills of those deploying for  $>6$  months, and the degradation was correlated with the length of time deployed. Most surgical specialists felt that it took them 3 to 6 months to return to their clinical and surgical performance baseline upon returning from a deployment and that 6 months was the most amount of time they could be deployed without a significant decrement in skills.

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The military health care system is unique in that almost every physician, nurse, and medical and surgical technologist deploys to combat for  $\geq 6$  months during their active service

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careers. During these deployments, medical personnel are not always placed in the same jobs that they perform when not deployed.<sup>1</sup> Most operating surgeons are deployed as surgeons but can have a wide variation in practice scope and volume depending on the operational tempo and number of troops they support. Additionally, most of this deployed work consists of trauma and emergency surgery,<sup>2</sup> not necessarily a surgeon's or physician's primary subspecialty practice while not deployed.

It is estimated that most active duty general surgeons perform  $\geq 50\%$  of their cases through minimally invasive

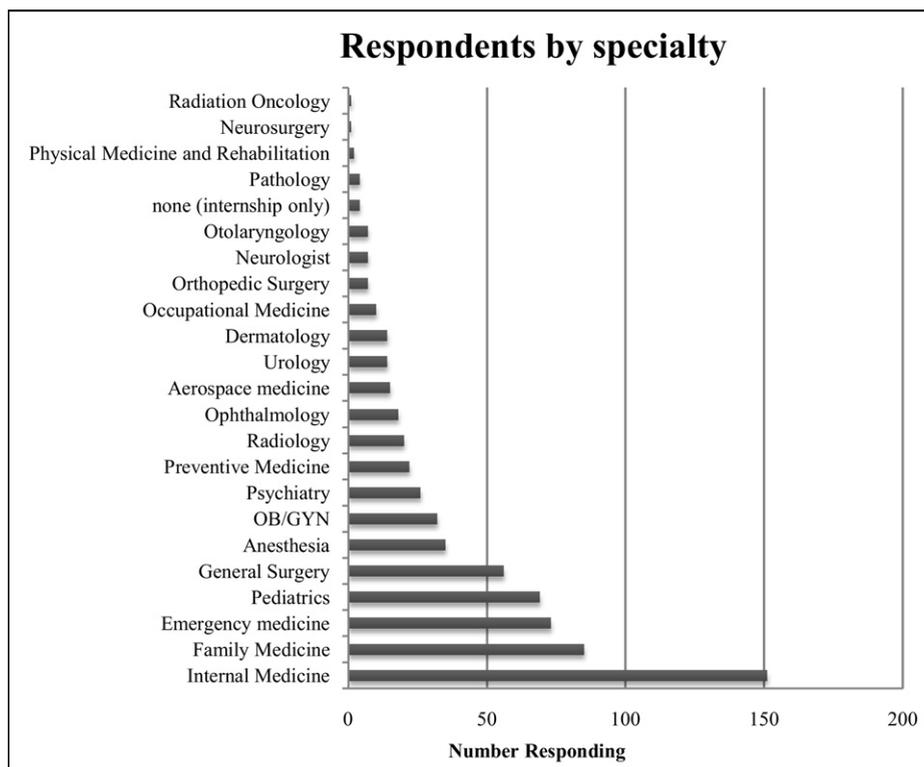
methods.<sup>3</sup> When deployed, surgeons do not manage patients with minimally invasive techniques in most settings, because of the inherent limitations of the combat environment: patient population, mainly a trauma mission while deployed, lack of instruments and equipment, and lack of appropriate facilities. Thus, the equipment and case mix are not available in most deployed settings for keeping up these skills. How long does it take operating surgeons to regain confidence and ability to reenter their busy practices upon their return from deployment? Is there a way to effectively and efficiently positively influence their integration back into practice through simulation? How will deployed surgeons maintain competence, as will be required by the maintenance of certification mandate imposed by the American Board of Surgery?<sup>4-9</sup> We sought to query end users, those potentially feeling the direct effects of artificially not being able to practice in their usual environments because of being deployed in combat and contingency operations in support of the United States about their experiences and perceptions of how their time away affected their surgical skills.

**Methods**

Questionnaires were sent to 1,500 active duty US Army physicians of all specialties who had deployed but were not part of a graduate medical education program in August 2007 at the request of the US Army Surgeon General's

Office. These names and e-mail addresses were provided by the office of the chief of the Medical Corps (Falls Church, VA) but were blinded to the authors, because this office also oversaw the distribution of the questionnaires. The survey questions were developed by consensus by the Army Medical Department's Central Simulation Committee. Questions regarded deployment experience of the queried physician, type of deployed unit and position, demographics of specialty and subspecialty training, board certification, years of experience, and perceived changes in clinical, surgical, and trauma skills. The category of surgeons queried included general surgeons, ophthalmologists, neurosurgeons, orthopedic surgeons, urologists, gynecologists/obstetricians, and otolaryngologists. General surgeons consisted of general surgery subspecialties (Military Occupational Specialty 61J), including thoracic, pediatric, vascular, plastic, oncologic, colorectal, minimally invasive, and trauma and critical care. Other medical specialties are depicted in Figure 1. Data for subspecialists were not delineated or specified any further except to ask how much they practiced their subspecialties while deployed if they had subspecialty training. Perceived skill assessments, before and after deployment, were assessed using Likert-type scales ranging from 1 (worst) to 7 (best).

This Web-based survey was performed using Survey-Monkey (Menlo Park, CA).<sup>10</sup> Results were collated and statistical analysis was performed using SPSS (SPSS, Inc, Chicago, Illinois) and Excel (Microsoft Corporation, Redmond, WA). Analyses of comparisons of noncontinuous data, such as



**Figure 1** Number of physicians per specialty who responded to the survey. OB/GYN = obstetrics and gynecology.

delay in board certification and deployed assignments, were performed using Pearson's  $\chi^2$  analysis. Student's *t* tests was used for continuous data analysis as appropriate. Analysis of variance was used to correlate perceived clinical and procedural skill degradation with amount of time deployed for both surgeons and nonsurgeons.

## Results

Fifteen hundred eligible physicians were sent surveys, with 673 full responses, for a response rate of 45%. There were 135 responses (20%) from surgeons and 538 from nonsurgeons (80%). Physician responders represented a broad cross-section of deployable surgeons and physicians (Fig. 1). Fifty-six respondents were general surgeons, representing 60% of deployable active duty general surgeons at the time of the study. On the basis of respondents' answers, there was a significant attempt to place surgeons in units that contained operating rooms (Fig. 2). Other potential locations for surgeons were leadership positions of any medical unit as well as with special operations forces.

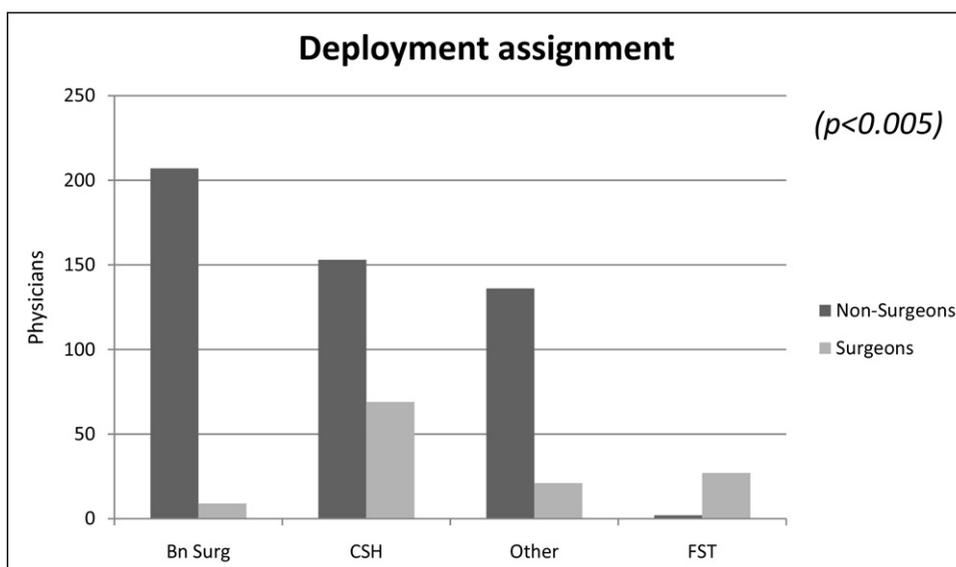
### Experience and board certification

Surgeons and nonsurgeon physicians were equally experienced when deployed, with >50% being <3 years from completing residency. Fifty-two percent of deployed surgeons were within 3 years of residency graduation, and 31% were >5 years from residency graduation. Operational deployments delayed obtaining board certification significantly more for surgeons than for nonsurgeons (16% vs 10%,  $P = .023$ ). The distribution of respondents for both surgeons and nonsurgeons was similar for the amount of

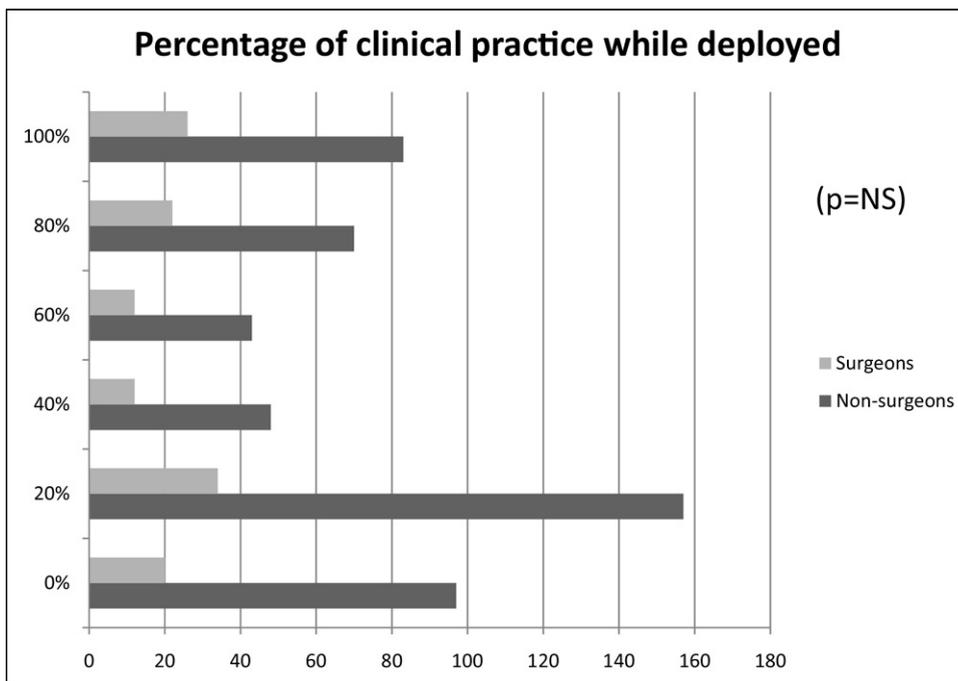
time spent practicing their trained specialties while deployed (Fig. 3). The reported deployed practice of general surgeons and general surgery subspecialists varied greatly. However, although general surgeons were more likely to declare that their deployed practice did match their usual practice, surgical subspecialists ranked a lower correlation between their deployed and US-based practices. Nonsurgeons reported significantly longer time away from their usual clinical practice because of deployments than did surgeons (Fig. 4).

### Impact on skills and suggested length of deployment

Both surgeons and nonsurgeons reported significant improvements in their trauma management skills after their deployments (average Likert scale increase from 4 to 6), without any difference between the groups (Fig. 5a). This correlated inversely with surgeon and nonsurgeon clinical skills before versus after deployment in that both groups perceived that postdeployment clinical skills had declined significantly ( $P < .001$ ). Furthermore, of those physicians who performed procedures, these skills were also perceived to decline significantly ( $P < .001$ ). When taking into account only surgeons operative skills, perceived degradation approached significance in correlation to time deployed ( $P = .07$ ). Both surgeons and nonsurgeons were likely to state that their deployed practice did not match their usual at-home clinical practice (Fig. 3). Possibly related to this mismatch of practice, surgeons stated a significant decline in clinical skills after deploying (average from 6 to 4,  $P < .005$ ; mode decreasing from 7 to 4) (Fig. 5b). Most surgeon and nonsurgeon respondents felt that it took approximately 6 months to regain clinical skills to their former baseline after returning from deployment and that the longest they



**Figure 2** Primary assignment of physicians and surgeons while deployed. Bn Surg = battalion surgeon; CSH = combat support hospital; FST = forward surgical team.



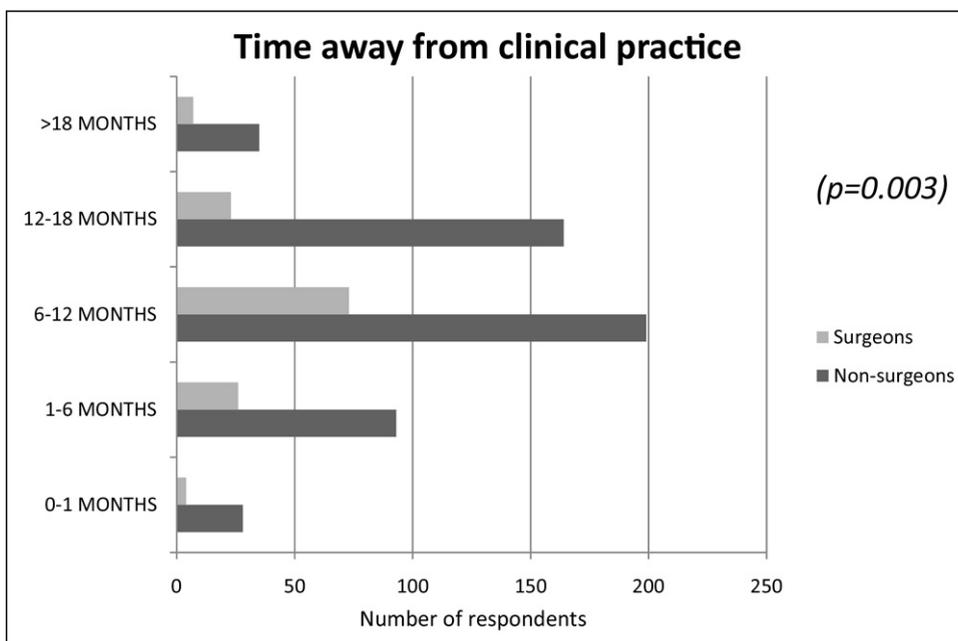
**Figure 3** Percentage of time surgeons and nonsurgeons spent performing clinical work in their primary specialties while deployed.

could deploy without a significant loss of clinical skills was between 3 and 6 months (Fig. 6).

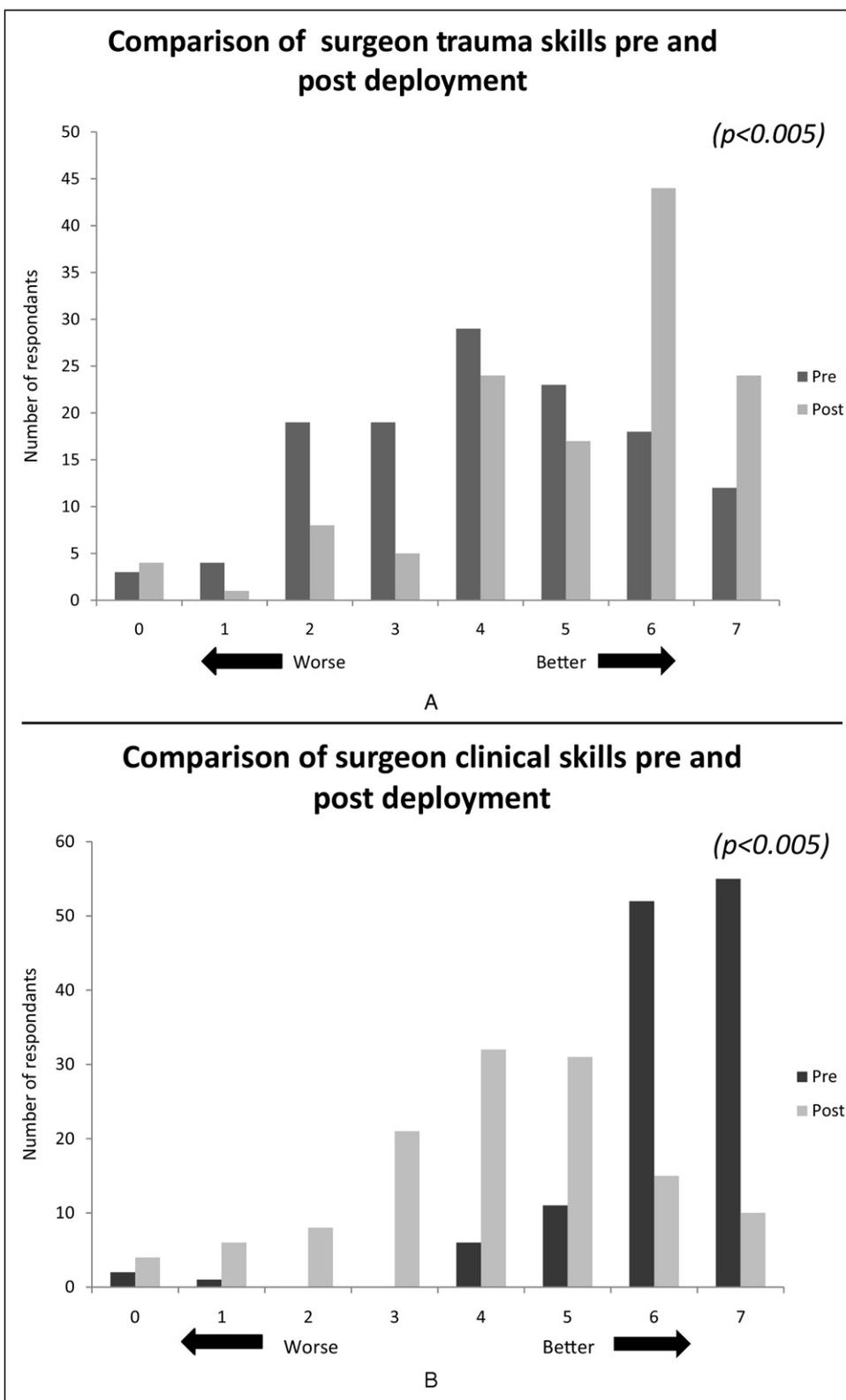
**Comments**

The results of this study show that the environment and practice patterns that Army physicians are exposed to

while deployed are perceived as markedly different from those at their home posts. Even though there are very good training programs required that attempt to minimize the impact of transferring from one environment to another, these programs may not be optimal to make up for the entire skill set needed for deployment in terms of transition to deployed skills and back. This was shown to be a concern of both nonsurgeon and surgeon physicians.



**Figure 4** Reported time away from clinical practice.

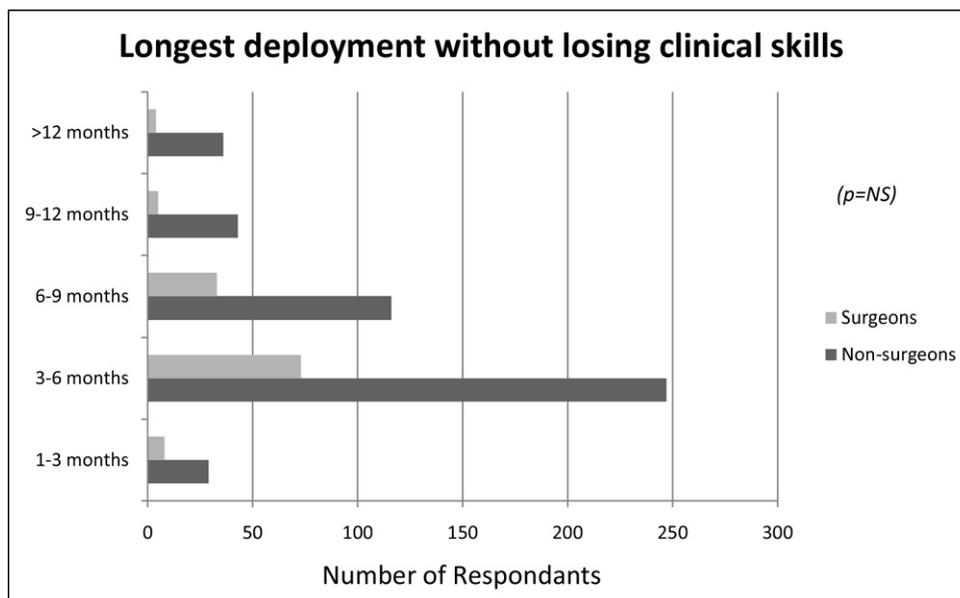


**Figure 5** Surgeons' trauma skills (A) and clinical skills (B) before and after deployment.

More than 50% of the general surgeons, the most frequently deployed specialty in the Army, spent  $\geq 80\%$  of their time doing what they were trained to do for a career in the military: trauma and acute care surgery on the

battlefield. However, this is not what most do at home on a routine basis.

Intuitively, predeployment trauma training for health care providers deploying to care for the injured on the



**Figure 6** Surgeons' and nonsurgeons' responses when asked how what the longest deployment should be without significant loss of clinical skills.

battlefield should be required if their home-based jobs do not involve caring for injured patients. Even so, battlefield trauma is uniquely different from most peacetime trauma practices (austerity, blast injury, evacuation routes). Similarly, those doctors and surgeons whose deployed practice is markedly different from their home-based practice (such as a colorectal surgeon who does only trauma in the deployed setting) would seem likely to benefit from postdeployment refresher training in their surgical subspecialties. The Army Surgeon General has instituted a policy that all hospital medical directors and department chiefs assess the individual personnel returning from deployment on the basis of deployed experience, overall surgical and patient experience, past performance, and length of deployment. However, mature courses to address “refresher training” have not been specifically and fully developed. Despite this study, we do not know whether there is a measurable degradation in clinical skills due to deployments of experienced physicians. Many have attempted to measure this in medical students and junior trainees, with divided results, and the transferability to trained surgeons is limited.<sup>11,12</sup>

Our study is essentially a needs assessment, the results of which have already had a significant impact on the policies and procedures of the Army Medical Department in using specialty-trained physicians and surgeons with both missions in mind: caring for troops in harm's way as well as providing a solid medical system back home for nondeployed troops, their families, and other beneficiaries. It is very timely with respect to many facets of medical care and the recent push for the refinement of the maintenance of certification process for many of the subspecialty boards of the American Board of Medical Specialties, where physi-

cian competence and favorable outcomes are clearly desired.

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# Physicians Reentering Clinical Practice: Characteristics and Clinical Abilities

ELIZABETH S. GRACE, MD; ELIZABETH J. KORINEK, MPH; LINDSAY B. WEITZEL, PHD; DENNIS K. WENTZ, MD

**Introduction:** Limited information exists to describe physicians who return to practice after absences from patient care. The Center for Personalized Education for Physicians (CPEP) is an independent, not-for-profit organization that provides clinical competency assessment and educational programs for physicians, including those reentering practice. This article studies the medical licensure status, performance, and correlates between physician characteristics and performance on initial assessment.

**Methods:** Sixty-two physicians who left practice voluntarily and without discipline or sanction and who were returning to practice in the same discipline as their previous practice participated in the CPEP reentry program. Physicians completed an objective clinical skills assessment including clinical interviews by specialty-matched board-certified physicians, simulated patient encounters, a documentation exercise, and a cognitive function screen. Physicians were rated from 1 (no or limited educational needs) to 4 (global, pervasive deficits). Performance scores were compared based on select physician characteristics.

**Results:** Twenty-five (40.3%) participants were female; participants' average age was 53.7 years (female 48.1 years; male 57.5 years). Physicians left practice for family issues (30.6%), health issues (27.4%), retirement or nonmedical career change (17.7%), and change to medical administration (14.5%). Females were more likely than males to have left practice for child rearing ( $P < 0.0001$ ). Approximately one-quarter (24.2%) of participants achieved a performance rating of 1 (best-performing group); 35.5% achieved a rating of 2; 33% achieved a rating of 3; 6.5% achieved a rating of 4 (worst-performing group). Years out of practice and increasing physician age predicted poorer performance ( $P = 0.0403$ ,  $P = 0.0440$ ). A large proportion of physicians presenting without an active license achieved active licensure; how many of these physicians actually returned to practice is not known.

**Discussion:** Physicians who leave practice are a heterogeneous group. Most participants' performance warranted some formal education; few demonstrated global educational needs. The data from this study justify mandates that physicians demonstrate competence through an objective testing process prior to returning to practice. Emerging patterns regarding the performance of the reentering physician may help guide future policy.

**Key Words:** reentry, return to clinical practice, demonstration of competence, licensure requirements, educational needs, clinical competence, physician workforce, physician shortage, self-assessment

## INTRODUCTION

The American Medical Association (AMA) suggests that fewer than 10% of physicians were on inactive status in

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2003;<sup>1</sup> this number rose to nearly 12% in 2007.<sup>2</sup> Physicians leave practice or become clinically inactive for a variety of reasons. Other than actual retirement, the reasons most often cited include care of family members, career and compensation dissatisfaction, health-related problems, pursuit of other careers, and sexual harassment.<sup>3,4</sup>

Following a period of inactivity, some physicians reenter practice. A study of Arizona physicians who renewed their medical licenses between 2003 and 2006 showed that 604 (4.6%) reentered clinical practice during this three-year time period,<sup>5,6</sup> an annual return rate of approximately 1.5%. Using this estimate of an annual return rate of 1.5%, and an actively employed United States physician population of 661,400 (Bureau of Labor Statistics, 2008)<sup>7</sup> close to 10,000 physicians may be returning from inactive status each year. State licensure boards as well as hospital and other credentialing bodies are increasingly faced with the question of how to ensure that it is safe to allow these physicians to resume practice.

Many states have addressed concerns about the competence of the reentering physicians by establishing policies that regulate new licensure or reactivation of a medical license after a time away from practice, but these policies vary greatly. Thirty of 68 member boards in the Federation of State Medical Boards (FSMB) responding to an AMA survey<sup>8</sup> reported that they have a policy regarding physician reentry; an additional nine boards are in the process of developing a policy.<sup>8</sup> **The duration of absence from clinical activity that causes a state licensure board to consider a physician as a reentry physician ranges from 1 to 5 years,<sup>8</sup> with 2 years or more being the most common criteria.** The licensure boards also have varying requirements for the reentry physician to demonstrate competence for licensure, ranging from providing evidence of continuing medical education activity to completion of a formal reentry program.<sup>8</sup> The reason for this broad array of requirements may be that little is known about precisely how time away from practice impacts physician competency, what risk factors indicate a need for educational remediation before or while returning to practice, and what kind of educational processes are effective in returning such physicians to practice.

There is limited published information about reentering physicians. The largest previously published study of reentry physicians in the United States is a study of 102 physicians who participated in a Medical College of Pennsylvania program between 1968 and 1976, published in 1978.<sup>9</sup> A follow-up study published in 1982 from the same program compared the participants from 1968–1975 and 1976–1981, which included a total of 181 participants (including the original 102 physicians).<sup>10</sup> Two studies about retraining such physicians were published in 1969 and 1972.<sup>11,12</sup> A resurgence of interest in physician reentry surfaced in the early 2000s, as indicated by a flurry of both scientific and lay press articles.<sup>3,13,14</sup> An article describing a program specifically for anesthesiologists to remediate or update their skills was published in 2006 and reviewed the experience of 25 physicians.<sup>15</sup> Respected professional organizations such as the American Academy of Pediatrics (AAP) and the AMA have expended effort gathering expertise and composing recommendations related to this topic. The AAP Division of Workforce and Medical Education Policy is the guiding force behind the Physician Reentry into the Workforce Project, a collaboration of several organizations that focuses on issues pertinent to reentering physicians (<http://www.physicianreentry.org/>). In 2008, the AMA Council on Medical Education released a report on physician reentry, which provided an overview of the status of reentry in the United States as well as 10 proposed guiding principles for physician reentry programs.<sup>5</sup> Notably, these guiding principles included a recommendation that the reentry programs have an objective mechanism to evaluate physician performance and that the programs are tailored to the needs of the individual physician.

The Center for Personalized Education for Physicians (CPEP) is an independent, not-for-profit organiza-

tion founded in 1990. CPEP provides clinical competency assessments and educational programs for physicians, including those returning to practice after an absence. CPEP programs are structured on the premises that education should be directed by an evaluation of the individual's educational needs<sup>16,17</sup> and that traditional continuing medical education conferences alone may not be effective in improving practice.<sup>18</sup> This approach is consistent with that of remediation programs both in the United States and internationally.<sup>17,19</sup> Since 2003, CPEP has evaluated 62 reentry physicians and has assisted many of those who needed remediation through a structured educational process. This article describes the characteristics, participant performance, and licensure status of those physicians, and potential correlates among physician characteristics and between physician characteristics and performance on initial assessment. Finally, this article will discuss whether the performance ratings of these reentering physicians support licensing board requirements to demonstrate competence after a time away from practice.

## Methods

The CPEP Reentry Program involves an initial skills assessment in the physician's area of intended practice and, if education or remediation is indicated, a supportive and structured educational process that takes place while the physician returns to practice.

CPEP evaluated 62 reentry physicians and assisted a portion of those who needed remediation through a structured educational process. All participants in this study were physicians (MD or DO). Physicians were eligible for this study if they left practice voluntarily, were under no state licensure board discipline or sanction, and were returning to practice in the same discipline as their previous practice.

At the time of enrollment, participants ( $n = 62$ ) provided demographic information (gender, age), information about their licensure status, and information about their professional status (reason for leaving practice and time away from practice) with the use of self-report forms; if information in the written intake form was unclear or missing, CPEP staff clarified the information through discussion with the participant. Licensure status was tracked because most of the participants enrolled to comply with a board rule to demonstrate competence, and the immediate objective of these participants was to gain licensure or relicensure. CPEP confirmed the licensure status at the time of enrollment as well as current licensure status (May 2010).

The physicians completed a clinical skills assessment that included 2–3 90-minute interviews conducted by specialty-matched board-certified physician consultants. In addition, the participants completed 2 (psychiatry) or 3 (all other specialties that involve patient contact) simulated patient encounters, a documentation exercise, cognitive function screen and, depending on the physician specialty, written testing. The number of interviews conducted varied due to changes

TABLE 1. Factors Considered in Determining Participant Rating and Description of Educational Processes

Factors Considered	Performance Rating			
	1	2	3	4
Demonstrated readiness for practice	Yes	Yes, with educational support	Yes, with initial period of supervision	No
Extent of educational needs	None to minimal	Moderate	Extensive	Global
Recommended educational process	Independent on-going education	Preceptorship (case discussion, chart review) Focused study (article review, CME) Medical information resources (Internet, hand-held devices)	Comprehensive specialty review Initial supervised practice (gradually increasing responsibility) Activities as described for rating 2	Training in residency setting
Estimated duration of educational process	NA	Two–four months	Four–nine months	Determined by residency

to the reentry protocol as it evolved over time, and due to a specific request by a referring state medical board that applicants who had been out for more than 10 years undergo a more rigorous evaluation because of the length of time out of practice; CPEP ultimately adopted this protocol and began to recommend 3 interviews for physicians who had been out for more than 10 years. Of the 14 physicians in this study who had 3 clinical interviews, 10 were physicians who had been out of practice for more than 10 years; the other 4 underwent 3 interviews for reasons determined by CPEP. Forty-eight physicians completed 2 clinical interviews, including 5 participants who had been out of practice for more than 10 years. Factors considered in determining the performance ratings were demonstration of readiness for practice and the extent and characteristics of educational needs identified. Two CPEP physician reviewers and the Executive Director reviewed the data from each participant and reached concurrence regarding the factors.

Those physicians who demonstrated readiness to return to independent practice were rated a 1; physicians with global educational deficits needing residency education were rated a 4. Physicians rated 2 and 3 demonstrated moderate to extensive educational needs; for these physicians, CPEP recommended completion of a structured educational process, which might include focused study, coursework, preceptorship, or chart review. The primary difference in these ratings is that the latter had more extensive educational needs and, thus, more intensive education was recommended, including initial practice in a supervised setting with gradually increasing independence. The factors considered in determining the performance rating and a brief description of the potential

educational recommendations are elaborated in TABLE 1. A portion of the participants who completed the assessment component enrolled in the education component of the reentry program. SAS version 9.2 (The SAS Institute, Cary, NC) was utilized for all statistical tests. Fisher's exact tests were performed (see TABLE 2) to relate primary reason for leaving practice to gender. Reason for leaving practice was coded as a dummy variable for this analysis (0,1), and a separate test was run for each reason for leaving practice. In TABLES 3 and 4, 1-way analyses of variance (ANOVAs) utilizing the general linear models were employed to test the relationship between physician rating, time out of practice, and age. A multivariate model was not tested because time out of practice and age were highly collinear variables. Fisher's exact test was performed to evaluate licensure status at the time of the initial assessment and assessment performance.

## Results

### *Description of Participants*

Twenty-five (40.3%) of the participants were female. Ages of the participants ranged from 31 to 73 years, with an average age of 53.7 years (female 48.1 years; male 57.5 years). The majority of the participants (49 or 79.0%) enrolled in the reentry program in order to demonstrate competency after time away from practice for a state licensure board; some came at the recommendation of a hospital (4, 6.5%) or other organization (4, 6.5%), and some were self-referred (5, 8.1%). The majority (46 or 74.2%) of physicians had

TABLE 2. Primary Reason Reported for Leaving Clinical Practice by Gender

Primary Reason for Leaving Practice	Female	Male	Total Number of Participants	P Value* (Fisher's Exact)
Administrative position	1	8	9 (14.5%)	0.0716
Personal: Child rearing	14	3	17 (27.4%)	<0.0001
Personal: Care of spouse	1	1	2 (3.2%)	1.00
Health: Medical	6	8	14 (22.6%)	1.00
Health: Psychiatric	1	2	3 (4.8%)	1.00
Nonmedical career	0	3	3 (4.8%)	0.2663
Personal: Other	1	5	6 (9.7%)	0.3870
Retired	1	7	8 (12.9%)	0.1286
Total	25	37	62	

\*P value relating gender to primary reason for leaving practice.

TABLE 3. Rating on Assessment by Years Out of Practice: Range of Performance and Average Rating

Years Out of Practice	Number of Participants to Achieve Each Rating				Total	Average Rating
	1	2	3	4		
1–5 years	7 (36.8%)	5 (26.3%)	7 (36.8%)	0	19	2.00
6–10 years	6 (21.4%)	13 (46.4%)	7 (25%)	2 (7.1%)	28	2.18
11–15 years	2 (20%)	2 (20%)	5 (50%)	1 (10%)	10	2.50
>16 years	0	2 (40%)	2 (40%)	1 (20%)	5	2.80
Total	15	22	21	4	62	2.23

**Note:** Years out of practice is significantly related to physician rating ( $P = 0.0403$ ) with the use of a general linear model in SAS version 9.2.

either an inactive/lapsed/expired license or no license in the state in which they wished to enter practice at the time of enrollment.

Participants left practice for a variety of reasons, such as family issues including care of family members (30.6%) [child-rearing 27.4%; care of a sick spouse 3.2%], health issues (27.4%), retirement or leaving medicine to pursue a different career (nonmedical career change (17.7%), and to assume a medical administrative position (14.5%) (see TABLE 2). When comparing reasons for leaving practice to gender, the data showed that females were more likely than males to leave practice for child-rearing purposes ( $P < 0.0001$ ). The association between leaving for an administrative position and gender approached significance ( $P = 0.072$ ) with males choosing this route more often than females.

The time out of practice averaged 8.1 years, and ranged from 1.5 years to 23 years. Participants were preparing to return to a variety of specialties, including primary care (internal medicine, family medicine, pediatrics, and general practice) (48.4%), surgery and surgical specialties (14.5%), psychiatry (9.7%), obstetrics/gynecology and subspecialties

(6.5%), internal medicine subspecialties (6.5%), anesthesiology (4.8%), and others (9.7%).

#### Participant Performance

Approximately one-quarter of participants (15, 24.2%) achieved a performance rating of 1 during their assessment; 69.4% demonstrated a performance rating of 2 (22, 35.5%) or 3 (21, 33.9%), and a small portion of the participants (4, 6.5%) achieved a performance rating of 4.

**Participant performance was also analyzed based on time away from practice and the results are shown in TABLE 3. Years out of practice was significantly related to performance rating ( $P = 0.0403$ ).**

Physician performance ratings were also analyzed based on participant age category (see TABLE 4). Physician age category was significantly related to performance rating ( $P = 0.0440$ ) with older physicians more likely to have higher ratings. There was no significant relationship between licensure status at the time of the assessment and performance in this small data set ( $P = 0.4641$ ).

TABLE 4. Rating on Assessment by Participant Age

Age	Number of Participants to Achieve Each Rating				Total	Average Rating
	1	2	3	4		
30–39 years	1 (20%)	2 (40%)	2 (40%)	0	5	2.20
40–49 years	6 (40%)	6 (40%)	3 (20%)	0	15	1.80
50–59 years	4 (16%)	11 (44%)	10 (40%)	0	25	2.24
60–69 years	3 (25%)	3 (25%)	5 (41.7%)	1 (8.3%)	12	2.33
70–79 years	1 (20%)	0	1 (20%)	3 (60%)	5	3.20
Total	15	22	21	4	62	2.23

Note: Age category is significantly related to physician rating ( $P = 0.0440$ ) with the use of a general linear model in SAS version 9.2.

TABLE 5. Licensure Status

Performance Rating	Active License at Enrollment	Active License May 2010
All participants	16 (25%)	41 (66%)
1	5 (33%)	14 (93%)
2	4 (18%)	15 (68%)
3	5 (24%)	11 (52%)
4	2 (50%)	1 (25%)

#### Licensure Status and Practice Outcomes

Licensure status was determined based on the state in which the physician reported that he/she intended to seek licensure or practice. Licensure status at the time of presentation was compared to current licensure status (May 2010). CPEP was able to confirm the accuracy of the self-reported status for 46 (74.2%) of physicians; because of the way licensure status is recorded on some board Web sites, CPEP was not able to confirm initial status for the remaining 16 physicians. CPEP staff confirmed the current (May 2010) licensure status for all physicians. Licensure status is presented in TABLE 5.

At this time, CPEP does not know whether physicians who did not have continued involvement with CPEP education programs have actually returned to practice. For the 22 physicians who enrolled in the education component of the reentry program, 16 completed their educational process, and each of these physicians was in active practice during and at the completion of the educational process. An additional 3 physicians are currently enrolled, 2 of whom are actively engaged in practice. Three physicians withdrew prior to completion of the program.

#### Discussion

The authors believe that this article provides information about the largest series of reentering physicians since the description of physicians reentering practice through the Medical College of Pennsylvania program, published in 1982.<sup>10</sup>

CPEP's assessment of reentry physicians indicates that physicians who leave practice for a prolonged break are a heterogeneous group, the majority of whom demonstrate educational needs that warrant some structured education before reentering practice. In this data set, approximately two-thirds of participants currently have active licenses in comparison to 25% at enrollment, indicating that they have been able to address licensing board requirements. Most of the physicians who completed the education components and for whom follow-up data were available achieved their stated goal of returning to practice.

#### Characteristics of Reentry Physicians and Their Reasons for Leaving Practice

Among CPEP reentry program participants, approximately 12.9% left practice intending to retire, whereas 4.8% left medicine to pursue a nonmedical career. Another 14.5% left practice for a nonclinical medical administrative role. Male physicians may be more likely to leave for a medical administrative role than females. Seventeen percent of participants cited child rearing as their reason for leaving practice. Female physicians in this group were statistically more likely to leave practice for child rearing than their male counterparts.

Physical and mental health conditions are cited as reasons that physicians might require prolonged absences from clinical practice. CPEP findings were similar to a study of Australian nurses returning to practice, in which health of the individual or a family member was implicated in 16 of 69 cases (23.2%).<sup>20</sup> In the CPEP study, 27.4% of physician reentry candidates indicated that personal health conditions

were the reason that they left practice. The majority of the health conditions were physical health conditions including stroke, closed head injury, and multiple sclerosis, rather than mental health conditions. Psychiatric conditions included depression and substance abuse. CPEP excluded physicians from the program who had disciplinary board stipulations or orders; therefore, physicians who had discipline related to health conditions such as substance abuse were excluded from this study.

#### *Participant Performance*

Approximately one-quarter of the physicians who completed the clinical skills assessment demonstrated minimal educational needs and were adequately prepared for a return to independent practice at the time of the assessment. The majority (67%) were found to have educational needs requiring moderate to considerable reeducation or updating, and another 6.5% showed educational needs that were broad enough to recommend education in a residency program to prepare for a return to practice (performance rating of 4). These data tend to confirm the concern of licensure boards that many reentering physicians may not be ready to jump back into practice; they also tend to justify mandates that physicians demonstrate competence through an objective testing process prior to returning to practice.

#### *Participant Licensure and Return to Practice*

The primary reason that physicians enrolled in the CPEP Reentry Program was to meet state board licensure requirements. This study found that many of the participants who presented to the program without an active license went on to obtain a license. This study did not include specific follow-up with participants to determine whether they actually returned to practice. There was a relatively small subset of physicians who participated in a structured educational process with CPEP and for whom data were available to suggest they were successful in returning to practice.

It is not yet clear whether a physician's demonstrated abilities and readiness to return to practice can be predicted. Other studies have shown a correlation between increasing age and poor performance on competency assessment in different physician populations.<sup>19,21-23</sup> The data presented here support similar conclusions for the reentry physician population. This data also indicate that time away from practice correlated with worse performance. If additional studies confirm these trends, licensing boards may choose to consider varying requirements, based on time away from practice and/or the age of the physician. Interestingly, there was no significant relationship between initial license status at the time of presentation and performance in this dataset; thus, having an active license at the time of reentry did not correlate with better performance in the CPEP program. This may be relevant as boards begin to consider how to regulate the inactive physician who has maintained an active license.

#### *Limitations*

This study is limited by the relatively small number of physicians studied, which may have impacted the ability to identify statistical significance with some variables. Some of the physician characteristics reported are self-reported, such as the reason for leaving practice. The extent of educational activities undertaken by the participant prior to enrollment was not evaluated. Although CPEP encouraged participants to prepare prior to the reentry assessment, this was left up to the individual participants. Therefore, the authors cannot comment on the possible impact of individual preparation on performance. With consideration for the developing nature of the CPEP process, including individualization of assessment, each physician did not undergo exactly the same evaluation process, such as two versus three interviews. CPEP utilizes oral interviews in the evaluation of physicians, which allows for tailoring an evaluation to the physician; such interviews can be criticized due to potential subjectivity. CPEP strives to address this in its training processes and assessment structure.

#### *Implications*

Physicians have been shown to be poor at analyzing their educational needs, and the more significant the physician's needs, the more significant the discrepancy in self-perceived versus actual educational needs.<sup>24</sup> This suggests that it may be difficult for physicians returning to practice to plan for and gauge their readiness for return accurately. Licensing board mandates that require a reentry physician to demonstrate competency through an objective assessment process prior to consideration for licensure or reactivation of licensure, and to follow through with educational recommendations, create barriers of time and cost for the reentering physician. However, the first priority of the licensing boards is patient safety, and the boards must create policies that are consistent with the mission of ensuring the competence of licensees.<sup>25</sup> Assessed competency with educational recommendations appears justified, based on the findings of this study. Further analysis of potential correlates with performance may allow more tailored approaches based on physician characteristics or circumstances.

#### *Unanswered Questions and Future Research*

Especially in light of growing concerns about the physician workforce,<sup>26,27</sup> the issue of physicians returning to clinical practice after a prolonged absence is of major importance. The magnitude of the phenomenon of physician reentry is uncertain, but it may include thousands of physicians each year. Though many state licensure boards and hospitals have established policies to manage reentry physicians, the policies vary significantly from state to state regarding the duration of absence from practice that would trigger a reentry process, acceptable options to demonstrate competence,

and the educational process required prior to licensure or reactivation.<sup>8</sup>

It is not yet clear whether a physician's demonstrated abilities and readiness to return to practice can be predicted, but data from this study show a relationship between time away from practice and increased age and poorer performance. Additional study is warranted to learn more about the reentry physician and potential predictors of performance.

### Lessons for Practice

- Through an objective assessment of competence, physicians returning to practice can be assisted in identifying gaps in knowledge prior to their return to patient care.
- A majority of participants who enrolled in the Center for Personalized Education for Physicians (CPEP) reentry program demonstrated moderate to significant educational needs.
- Physicians who participated in a supportive, structured educational program were generally successful in achieving their goal of restoring licensure and returning to practice.
- Emerging patterns indicate that certain physician characteristics (age, time away from practice) may help predict performance.

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## **Skills fade: a review of the evidence that clinical and professional skills fade during time out of practice, and of how skills fade may be measured or remediated.**

### **1. Introduction**

This is an exploratory study looking at skills fade in the health sector, particularly in doctors. It doesn't seek to make policy recommendations, rather to survey the evidence on the topic. The scope of this review is to identify what evidence there is to say when and how time out of practice affects skills, competence and performance. The review has looked at:

- how important the length of break from practice is
- how this impact differs by type of practice
- mitigating factors for any reduction of skills.

This review has gathered evidence from the published literature on doctors, other health professions and from other skilled professions.

### **2. Background**

Time out from professional practice may happen for a variety of reasons:

- maternity, paternity or family leave;
- ill health;
- suspension;
- a career break or foray into another career;
- extended travel or
- study leave.

It makes sense that time out may affect skills and competence. Understanding the impact would enable the professional, their employer and their regulatory body to find a way to address any training or support needs.

This issue interests us because it's our duty to protect the public by making sure that doctors meet the expected standards of good medical practice. The various ways of regulating and monitoring performance through revalidation should provide assurance of the good medical practice of working doctors (Locke et al, 2013). But doctors returning from a break in practice are a potential area for concern. As the Academy of Medical Royal Colleges (AoMRC) (2012b, 2012c) points out, within the current licensing and revalidation framework, there can be a gap between a doctor's return to practice and their review at appraisal and revalidation.

Some breaks in practice are the result of the doctor being suspended as part of fitness to practice proceedings; either by an interim orders panel while an investigation is being carried out, or by a fitness to practise panel at the end of the hearing. Case (2011a, 2011b) discusses the unintended effects of interim suspensions on doctors, saying the impact can be more punitive and severe than the final sanction (p364). She talks of 'a costly de-skilling effect which needs to be 'addressed before the doctor returns to practice'.

The Department of Health (2000) in its consultation on modernising medical regulation also raised public protection concerns about restoring doctors to the register 'after a lengthy period of erasure or after a formal reassessment of skills.' In 2003, a National Audit Office report on the effects of suspensions of hospital and ambulance staff in the

NHS in England pointed out that one of the costs of suspension is the risk of loss of clinical skills, which in turn may impact on patient safety.

### **3. Research questions**

We wanted to find out:

- 1) Is there any evidence to suggest that an individual de-skills over time out from practice and if so, over what period of time?
- 2) What factors affect skills fade and how – for example, age, specialty, supervision, level of autonomy etc.
- 3) Do other comparable regulators do anything to assess performance after a prolonged break in practice? If so, why did they introduce such assessments and what is the evidence base behind it?

### **4. Research strategy**

This research used a systematic approach to identify and evaluate written evidence to answer the study research questions.

This incorporated a literature search and web-based review of online publications.

A systematic review of the medical literature has been undertaken using online databases.

The literature has been evaluated for quality and for relevance to the research questions.

The content of relevant papers has been summarised in order to answer the review research questions.

### **5. Research methods**

This review was carried out in three phases:

- In the first phase, published evidence on the impact of time out on doctors was systematically searched for, reviewed and summarised.
- In the second phase, published evidence on the impact of time out on other regulated health professionals was systematically searched for, reviewed and summarised.
- In the third phase, published evidence on the impact of time out on work-related skills and competence was systematically searched for, reviewed and summarised.

A call for evidence was also sent out via email to fellow medical regulators internationally. This gathered eight responses.

### **6. Overview of the quality and relevance of the included papers**

Overall, the topic of skills fade after a break from practice on the part of doctors or other health professionals has not been studied widely. There is a body of research looking at retention of skills after a period out of practice, or after a gap since learning certain skills. There is also one looking at the opinions and experiences of medical and other healthcare professionals who are returning to work.

There have been other studies on skills fade, both of people working in healthcare and other professions. Some research papers of note were found on the subjects of doctors, dentists, nurses, occupational therapists, pharmacists and physiotherapists. No papers of relevance to this review were found on opticians or veterinarians.

There have been studies on skills fade in railway workers, machinery operators, pilots and army personnel. The most comprehensive analyses of skills fade have been undertaken by research teams looking at armed forces service personnel. The theoretical basis for the understanding of skills retention and skills fade comes from cognitive psychology and some studies have measured skill retention using experiments involving volunteers (usually university students).

The quality of the primary research studies mentioned is generally high. The studies follow good practice in terms of data collection, analysis and reporting, and taking into account the nature of the research conventions suitable to their research questions. However, many studies use small sample sizes and report considerable attrition between tests of retention. They also tended to be single site studies. For these reasons, any generalisations from findings should be cautiously made.

Military researchers carried out larger scale reviews of the evidence on skill retention. They drew on a similar pool of evidence but incorporated primary and secondary research into reports on the literature.

In many studies it isn't clear how often practice and revision has been undertaken by subjects between tests. There are many studies looking at retention of learning in novices and only a limited body of research looking at how experts or those with years of practice retain their knowledge. Studies have also tended to look at single skills or single sets of skills rather than overall competence in a role.

The applicability of findings from studies outside medicine is limited, given the often specific nature of the skill being assessed. Within the medical and health literature, reports on skill retention have mainly looked at the impact of training interventions.

## **7. Answering the research questions**

### **7.1 Is there any evidence to suggest that an individual's skills fade over time out from practice and if so, over what period of time?**

There is substantial evidence that time out of practice does impact on the individual's skills. Skills have been shown to decline over periods ranging from six to 18 months, according to a curve, with a steeper decline at the outset and a more gradual decline as time passes. The amount of time between learning and losing a skill varies between skills and between individuals, with many mitigating factors. Studies have tended to look at skill retention at intervals up to two years. This has more to do with the time limited nature of research studies than two years necessarily being a vital cut off period.

This review has found no clear consensus about what length of break from practice ought to result in an assessment of competence. This depends on the skill being assessed, their original training and other issues such as how long they have practiced the skill and how often.

## **7.2 What factors tend to influence and mitigate for skills fade – for example, age, specialty, supervision, level of autonomy etc.**

Evidence from several studies looking at retaining specific clinical, surgical and life support skills suggests that level of prior expertise and opportunity to practise similar skills in the interim can help the individual's ability to retain a particular skill. The concept of over-learning is key here, given that the evidence from military studies shows that the higher the level of learning and proficiency prior to the break from work, the higher the level of retained skill will be.

There is a consensus that skills fade may be mitigated through keeping in touch with peers during a break from work and staying aware of relevant developments.

There's evidence that self-assessment of competence doesn't necessarily match the findings of more objective assessments. This has potential patient safety implications, and suggests that self-assessment wouldn't be enough to determine how skills fade should be addressed.

Grace et al's (2011) study suggests that older age and length of time out can lead to lower performance scores when the returning individual's skills are assessed. The results of this study are clearly relevant to this review, just as they were to the AoMRC return to practice review.

The conclusions of reviews in both the military and in industrial and professional literature are that competence retention and deterioration depends on organisational, job or task training and assessment and individual factors. The degree of influence these factors have, and the nature of influence that specific aspects of, say, the individual's personality or experience have, has not been widely posited or tested outside of the military research field. As such, all these should be taken into account when assessing or addressing the fade.

## **7.3 Do other comparable regulators undertake any form of performance assessment following a prolonged break in practice? If so, what led to the introduction of this assessment and what is the evidence base behind it?**

Health professional regulators have various responses to practitioners wanting to return to practice after time out. Within medicine, UK doctors must at present meet revalidation requirements in order to show their ongoing fitness to practise. They must also abide by the requirements of their Royal College about maintaining skills and knowledge. There are specific requirements for doctors in training about stepping off and back onto their training programmes.

Outside the UK, various approaches are used. In Finland, the Republic of Ireland and France there are no requirements placed on doctors to prove their fitness to continue to practise on returning after a break. Australia and New Zealand have statutory requirements about proving fitness to continue to practise, particularly if the break is longer than three years. In the US, different State Medical Boards have different requirements regarding returning to work. There are no reports of particular performance assessments that take place, although some US state boards and the Registrar of the Medical Council of New Zealand may require one to be undertaken.

The health professional regulators in the UK have requirements regarding CPD that must be met in order to return to the register. The NMC does validate return to practice courses but there is variation between such courses in terms of their length and content. The HCPC requires returners to undertake 30 days of updating if they are out for over two years and 60 days updating if they take over five years out.

## 10. Conclusion

This review has found limited and mixed evidence to support the notion that skills decline over a fixed period of time.

Health professionals may take time out from professional practice for various reasons. This time out may be accompanied by removal from the register for that profession. It may also be as a result of removal from or suspension from the register. There is little known about the impact that this time out may have on the registrant's competence, performance and skills.

Whilst the requirements for re-registration are set down in legislation, there's little evidence on how exactly those requirements were determined.

There's evidence that skills decline according to a curve, with the greatest decline being during the first few months, and subsequent decline being at a much slower rate. However, other studies contradict this.

Many studies of retaining specific skills measure retention at six, 12, 18 and 24 months. There is some consensus between health professional stakeholders that two or three years out of practice should signify a need for reassessment and retraining prior to a full return.

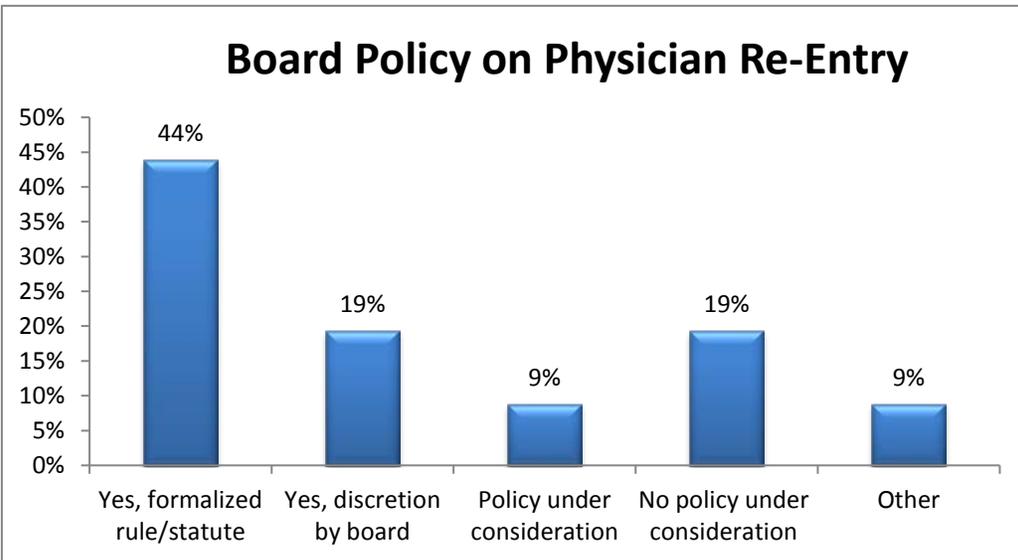
There is limited evidence to determine exactly how time out of the profession affects doctors and other health professionals' skills. This limitation is due to there being a limited number of studies on this topic rather than there being poor quality or inconclusive evidence. The largest body of evidence comes from tests of retention of specific skills learned through training, rather than from studies of health professionals before and after time out. Outside of medicine, skills fade has been a matter of concern for organisations requiring high reliability and a strong safety culture. Evidence from the military, in particular, shows that skills retention and fade are influenced by multiple factors, not just the individual.

Skills decay is a complex phenomenon. It is influenced by a range of factors. Health professional practice involves the performance of a range of skills in a range of contexts. These skills may decline at different rates for different people in different settings. The model of skill retention posited by military researchers weights individual, organisational, task, training and interval factors. Attempts to determine how these factors impact have shown they do influence the degree to which skills are retained, but how they interact has not conclusively been shown.

Future research to determine how best to assess and mitigate skills fade when a practitioner returns to work should take account of individual circumstances and the range of influencing factors. Further research in this area is needed, especially looking at retention of global as well as specific skills and looking at retention of skills in experts as well as novices.

Does your board have a policy on physician re-entry to practice?

Response	Frequency	Percent
Yes, through a formalized rule or statute	25	43.9%
Yes, at the board's discretion/on a case-by-case basis	11	19.3%
A policy is under consideration by the board	5	8.8%
No policy is under consideration at this time	11	19.3%
Other	5	8.8%
Total	57	100.0%



Yes, formalized rule/statute  
 Yes, discretion by board  
 Policy under consideration  
 No policy under consideration  
 Other

"Other" Responses Specified

Response	Frequency	Percent
Discussed but not currently	1	20.0%
If a Dr. allows his/her license to become null ar	1	20.0%
Policy is under consideration with Bd of Medic	1	20.0%
unwritten policy taken on a case by case basis	1	20.0%
we have very minimal references in rule	1	20.0%
Total	5	100.0%

## Physician Re-entry

The AMA defines physician re-entry 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.” Many states have specific rules for physicians seeking to reenter clinical practice, and some require passage of the Special Purpose Examination (SPEX), Comprehensive Osteopathic Medical Variable-Purpose Examination (COMVEX), or similar examinations to prove current competence (Table 25).

In the AMA’s 2011 Physician Licensure Survey, the following questions on re-entry were included; the response rate was 88 percent (57 of the 65 Boards surveyed):

- Does your board require a physician to engage in a certain amount of patient care for relicensure?  
7 percent (n=4)
- Does your board ask physicians to provide information on the average amount of time they engage in patient care?  
13 percent (n=7)
- Does your board have a policy on physician re-entry for physicians who have left the active practice of medicine and want to re-enter practice?  
58 percent (n=33)
- What is the length of time out of practice after which your board requires re-entering physicians to complete a re-entry program?  
2.9 years
- Are you keeping records on the number of physicians the board considered for re-entry? (Asked of the 33 boards with re-entry policies only)  
24 percent (n=8)
- Is your board currently developing or planning to develop a re-entry policy? (Asked of the 24 boards with re-entry policies only)  
50 percent (n=12)

### AMA recommendations on physician re-entry

In 2010, the AMA worked with a wide range of stakeholders—including leaders in licensure, board certification and medical education, as well as directors of re-entry programs—to develop the following recommendations on physician re-entry. In particular, the American Academy of Pediatrics and Federation of State Medical Boards contributed to the consensus process leading to these recommendations.

*Note:* For more information on this and other aspects of physician re-entry, refer to the AMA’s Physician Re-entry website at [www.ama-assn.org/go/reentry](http://www.ama-assn.org/go/reentry).

### Regulatory policies

Principle: Ensure that there is a comprehensive, transparent and feasible regulatory process for physicians to return to clinical practice.

1. Develop an understanding of the expectations and needs that relevant stakeholder groups—physicians, patients, regulators and the public—have for a physician re-entry system.
2. Develop physician re-entry 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 re-entry process
  - The definition of how much involvement in clinical care constitutes active clinical practice and the clinical practice requirements for maintaining licensure
  - 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 re-entry 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 that allow re-entry program participants to work under supervision
  - State medical licensing boards that establish a non-disciplinary licensure status option for reentering physicians during their re-entry education and training
  - Development and validation of a process for previously board certified physicians not eligible for maintenance of certification to participate in re-entry training necessary to return to their field and original scope of clinical practice

4. Work with state medical licensing boards and medical societies to develop a certificate of program completion that meets the need to document physician readiness for clinical practice.

### **Physician re-entry program policies**

Principle: Develop policies that assure the quality of re-entry programs and the readiness to resume practice of their graduates.

5. Increase consistency among re-entry programs by establishing a mechanism by which programs can assess and demonstrate graduates' comparable preparation and readiness for independent practice within the physician's intended scope of practice.
6. Encourage the development of modular programs to meet the specific learning needs of individual reentering physicians.
7. Consider a physician re-entry program accreditation process that includes a review of program outcomes.

### **Research and evaluation**

Principle: Create an evidence base that can be used to inform policymakers, reentering physicians and re-entry program development.

8. Study the feasibility of introducing alternate licensure tracks for reentering physicians that allow a limited scope of practice.
9. Study the relationship between time away from practice and maintenance of clinical knowledge, skills and behaviors.
10. Study new models of organizing physician re-entry programs to include the feasibility of providing physicians with an educational "home" base.
11. Continue to develop valid and reliable assessment tools for physician knowledge and skills. Assessment of reentering physicians should occur at three points: (1) entry to a physician re-entry program, (2) completion of a physician re-entry program, and (3) a standard time after which a physician has returned to active clinical practice.

12. Establish a national physician re-entry database to:
  - Provide programmatic information to reentering physicians
  - Track trends in re-entry such as number of reentering physicians, program costs and outcomes

13. Study the workforce implications of a system that supports physician re-entry.

### **Program funding**

Principle: Develop means to ensure that a physician re-entry system is financially feasible.

14. Pursue multiple funding streams to support the development, implementation and evaluation of a national physician re-entry system.

### **Collaboration and communication among stakeholders**

Principle: Ensure that all stakeholders participate in planning for a physician re-entry system.

15. Establish process for ongoing communication between medical regulatory bodies, physician re-entry programs, medical associations and societies, and other key stakeholders to further the development of a national re-entry system.
  - Mitigating the cost of physician re-entry programs for physicians and regulatory bodies
  - Supporting the development and maintenance of physician re-entry programs
  - Creating mechanisms for the assessment and evaluation of physician re-entry programs

16. Continue to educate medical students, residents and practicing physicians on career-planning strategies and resources should they need to take a hiatus from clinical practice.

**Table 25**  
**Physician Re-entry Regulations**

	Board has policy on physician re-entry to practice*	Length of time out of practice after which re-entry program completion is required	Board developing/ planning to develop policy	Decided on Case-by-Case Basis	SPEX/ COMVEX May Be Required	CME May Be Required	Notes
Alabama	No		No	Yes	Yes		
Alaska	No	—	No				Full board interview may be required
Arizona	Yes		—	Yes	Yes	Yes	PACE may also be required
Arizona DO	Yes		—	Yes	Yes	Yes	Practice monitoring may be required, structured as non-disciplinary probation.
Arkansas	Yes		—				
California	No		No	Yes			
California DO	Yes	5 yrs	—			Yes	Under 5 yrs: completion of questionnaire and 20 CME credits required. Over 5 yrs: new application required.
Colorado	Yes	2 yrs	—				Personalized competency evaluation report prepared by Board-approved program, and completion of any education/training that is recommended by the program.
Connecticut	Yes	2 yrs	—				
Delaware	Yes	3 yrs					
DC	Yes	2 yrs	—	Yes	Yes	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, 1 yr of clinical training in an ACGME- or AOA-accredited program or 300 Category 1 CME credits is required. Physicians who have been out of practice for 2 yrs or longer are required to undergo a re-entry plan as determined by the board to demonstrate current knowledge, skill, and proficiency. Formal regulations will be promulgated.
Florida	Yes	4 yrs	—	Yes	Yes	Yes	
Florida DO	Yes	4 yrs	—	Yes	Yes	Yes	Board recommends Univ. of Florida CARES or CAPS program. Applicant required to appear before Board and establish ability to practice in safe manner. Also required: COMVEX; an accounting for activities while not practicing.
Georgia	Yes	Board discretion	—				Demonstrate current knowledge, skill, and proficiency.
Guam							
Hawaii	No		No				
Hawaii DO							
Idaho	No		No	Yes	Yes		
Illinois	Yes	2 yrs	—				See Section 1285.95 of Administrative Rules.
Indiana	No		Yes	Yes			Personal appearance before board is required.
Iowa	Yes	3 yrs	—	Yes			Competency evaluation required.
Kansas	Yes	2 yrs	—				Additional testing, training, or education may be deemed necessary.
Kentucky	Yes	2 yrs	—	Yes			
Louisiana	No		No				Must meet requirements for reinstatement or relicensure.
Maine	No		Yes	Yes			
Maine DO	No		No				

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**Table 25** (continued)  
**Physician Re-entry Regulations**

	Board has policy on physician re-entry to practice*	Length of time out of practice after which re-entry program completion is required	Board developing/ planning to develop policy	Decided on Case-by-Case Basis	SPEX/ COMVEX May Be Required	CME May Be Required	Notes
Maryland	Yes	5 yrs	—	Yes	Yes		A physician with license on inactive status or who has failed to renew a license by the 2-month late renewal period and who wishes to practice medicine may apply for reinstatement.
Massachusetts	No		Yes				Must complete "re-entry to practice plan."
Michigan	No		No			Yes	Complete 150 hours of CME with a minimum of 75 hrs AMA Category 1 within immediately previous 3 yrs from date of application.
Michigan DO	No		No			Yes	(See above)
Minnesota	Yes	3 yrs	—	Yes	Yes	Yes	Assessment or mentorship may be required.
Mississippi	Yes	3 yrs	—				Board-approved physician assessment or clinical skills assessment program.
Missouri	No		Yes				
Montana	Yes	2 yrs	—		Yes		
Nebraska	Yes	2 yrs	—	Yes			May issue a re-entry license (Neb. Rev. Stat. 38-202601).
Nevada	Yes	1 yr	—		Yes	Yes	PACE, CPEP peer review, preceptorship, or fellowship may be required.
Nevada DO	Yes		—			Yes	Additional \$500 and proof of CME for inactive yrs required to reactivate practice.
New Hampshire	No		Yes	Yes			
New Jersey	Yes	5 yrs	—	Yes	Yes	Yes	See Board regulation NJAC 13:35-3.14
New Mexico	Yes	2 yrs	—			Yes	Mini-Sabbatical or CPEP may be required.
New Mexico DO							
New York	No		No				A licensed physician in inactive status must re-register.
North Carolina	Yes	2 yrs	—			Yes	Completion of re-entry program required. See 21 NCAC 32B.1370
North Dakota	No		Yes	Yes			Re-entry plan developed, as appropriate.
Ohio	Yes	2 yrs	—		Yes		Exam to determine current fitness to practice or Board certification or recertification examination may be required (Sec 4731.222)
Oklahoma	No		Yes				
Oklahoma DO	No		No	Yes			
Oregon	Yes	2 yrs	—				A physician out of practice more than 24 months may be required to take a competency exam or training. Refer to OAR 847-020-0183.
Pennsylvania	Yes	4 yrs	—		Yes	Yes	Re-entry to practice plan may be required, to include completion of a clinical skills assessment program, refresher training, mentorship program, a mini-residency, passing ABMS board exams, etc.
Pennsylvania DO	No		Yes		Yes	Yes	Additional training may be required, as well as completion of application and payment of fee.
Puerto Rico							
Rhode Island	No		Yes			Yes	Mentorship may be required.

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**Table 25** (continued)  
**Physician Re-entry Regulations**

	Board has policy on physician re-entry to practice*	Length of time out of practice after which re-entry program completion is required	Board developing/ planning to develop policy	Decided on Case-by-Case Basis	SPEX/ COMVEX May Be Required	CME May Be Required	Notes
South Carolina	Yes	4 yrs	—				
South Dakota	No		Yes	Yes		Yes	Re-entry to practice plan may be required, to include completion of a clinical skills assessment program, refresher training, mentorship program, a mini-residency, passing ABMS board exams, etc. It is the physicians's responsibility to demonstrate competence and fitness to practice.
Tennessee	Yes	5 yrs	—	Yes	Yes		Must display clinical competency.
Tennessee DO	Yes	Variable	—	Yes	Yes		Must display clinical competency.
Texas	No	See note					Applicants for licensure must have practiced full time for 1 of the 2 years preceding date of application. Licensees are not required to demonstrate active practice.
Utah	Yes	5 yrs	—		Yes		See R-156-67-302(d)(2).
Utah DO	Yes	5 yrs	—				
Vermont	Yes	3 yrs	—		Yes		
Vermont DO	Yes	1 yr	—		Yes		See Rule 2.3.2
Virgin Islands							
Virginia	Yes	4 yrs	—		Yes		
Washington	Yes	2 yrs (depending on specialty)	—		Yes		After 2 yrs out of practice, an application, fee, and CME credits are required; after 4 yrs, SPEX is usually required
Washington DO	No		No				
West Virginia	No	18 months	No	Yes			
West Virginia DO	No		Yes	Yes			
Wisconsin	No	5 yrs	Yes				Oral examination may be required. If less than 5 yrs, licensure renewal is allowed. Re-registration application is required (\$241).
Wyoming	No		No	Yes	Yes	Yes	Other requirements that may be imposed include preceptorship, supervision, chart review, and evaluation (CPEP).

\* 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**COMVEX**—Comprehensive Osteopathic Medical Variable-Purpose Examination**CPEP**—Center for Personalized Education for Physicians**PACE**—Physician Assessment and Clinical Education program**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.

# PHYSICIAN REENTRY THEMES & OPPORTUNITIES

***PHYSICIAN REENTRY INTO CLINICAL PRACTICE CAN BE DEFINED AS RETURNING TO PROFESSIONAL ACTIVITY/CLINICAL PRACTICE FOR WHICH ONE HAS BEEN TRAINED, CERTIFIED OR LICENSED AFTER AN EXTENDED PERIOD OF ABSENCE. THIS IS AN ISSUE THAT CUTS ACROSS GENDERS AND SPECIALTIES.***

## **Introduction**

In June of 2014 the American Medical Association (AMA) Council on Medical Education hosted a stakeholder’s session, “Re-Entry to Medical Practice: Defining the Needs for Medical Education.” During this session the AMA Council on Medical Education engaged stakeholders from diverse organizations in a discussion of how to address the challenges of reentering clinical practice and how to meet the needs of physicians reentering clinical practice. An outcome of this session was the identification of the following 8 reentry themes.

### **Reentry is an important topic for many stakeholders**

Reentry continues to be an important topic of discussion for many stakeholders (i.e. physicians, specialty societies, medical schools, medical boards, regulatory agencies and those involved with specialty certification/Maintenance of Certification). Specialty and state regulatory boards have a vested interest in the continued competence of physicians who leave and later reenter clinical practice, and how these physicians can maintain and demonstrate clinical competence in their profession. In addition, concerns around the capacity of the physician workforce and possible physician shortages has brought medical schools and others to the discussion regarding possible ways that reentering physicians might help lessen shortages and increase capacity.

### **Reentry crosses all specialties and genders**

Both surveys and anecdotal evidence support the idea that physician reentry is an issue that crosses all medical specialties and genders. In fact results from a national study conducted by The Physician Reentry into the Workforce Project and using AMA Masterfile data found that 50.4% of reentry physicians were female and

49.6% were male.<sup>1</sup> This same survey also found that for both men and women the top reasons for being inactive or leaving clinical practice were personal health issues and structure and practice of medicine issues (“hassle factor”, malpractice premiums, lack of professional satisfaction etc.). Both female and male physicians reported diverse reasons that might lead them to go back to clinical practice. For women the availability of part-time work and/or flexible work schedules had a strong influence on considering going back to clinical practice.

### **There is a need for data on reentry physicians and those currently out of clinical practice**

“How many reentry physicians are out there?” This is a question that is asked almost any time physician reentry is discussed. The only national survey of physicians and physician reentry (discussed above) did not allow for credible stratification by specialty.

### **Reentry efforts should move forward despite lack of data**

The lack of data on the numbers of reentry physicians has been a barrier to getting individuals and organizations to embrace both the concept of physician reentry and the need to assist these physicians. The cost and time involvement of national surveys, such as the one mentioned above, may be one of the reasons why this research has not been repeated.

There has been some movement forward in data collection. One such example is that in 2012 the Federation of State Medical Boards (FSMB) adopted a minimal dataset policy, which recommends that licensing boards include workforce questions as part of its license renewal process for physicians. As part of this work, a 2011 survey found that approximately half of all licensing boards indicated they collected at least some physician workforce data that includes information such as number of hours worked, practice location and full-time vs. part-time work. Although answering these questions is typically voluntary, collection of this information may be helpful in determining the number of potential reentry physicians.

In addition, there have been several published studies that look at physician reentry through the narrow lens of a specific program, specialty or a specific geographic area.<sup>2</sup> Despite the lack of firm data on the number of reentry physicians and the demand for reentry services, efforts to assist these individuals should move forward as the demand for reentry services, will depend, at least in part, on the perceived availability and feasibility of reentry programs.

### **Explore the differences and similarities of retraining, remediation, and reentering**

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<sup>1</sup> Jewett EA, Brotherton SE, Ruch-Ross H. A National survey of ‘inactive’ physicians in the United States of America: enticements to reentry. *Human Resources of Health* 2011;9:7 (17 February 2011).

<sup>2</sup> <http://www.physician-reentry.org/resources/reentry-physicians-reading-list/>

The resources a physician seeks in order to reenter clinical practice after a voluntary leave of absence, remediation, or retraining are often the same, though applied at different levels of intensity. Some reentry programs have grown out of already established programs that provide physician assessment and evaluation services for other issues (e.g., remediation, retraining). It may be worthwhile to consider how these programs may be used to help determine the demand for reentry resources as well as how these programs can help meet the needs of reentry physicians.

### **Developing reentry services and programs is challenging**

The development of reentry programs and services has its own set of challenges, including but not limited to, funding sources, an educational culture that may inhibit development of programs, standardization of programming and assessment, and programming that cannot be a one-size-fits-all approach to meet the needs of the reentry physician. As noted above, some reentry programs have developed out of already established programs; this can help defray the costs associated with developing and maintaining stand-alone reentry programs.

Additionally, while many current reentry programs are highly regarded, there is not a single model for reentry programs, and they are not subject to either standard requirements or external evaluation. The costs to participate in these programs can also be a significant barrier to physicians. Finally, the limited availability of programs to physicians and the variability in what programs may be able to offer to other interested stakeholders (medical boards, hospitals, malpractice insurers, etc.) can be challenging as well.

### **Need for robust communication**

It is not uncommon for physicians to leave clinical practice for a period of time during their career and then seek to reenter clinical practice. In fact, many believe leaving and reentering the clinical workforce should be regarded as a normal part of a physician's career path. The concept and implications of leaving clinical practice and the requirements and challenges in returning needs to be communicated to the physician community so that physicians can plan accordingly. The implications and challenges of reentry to clinical practice also needs to be communicated to the stakeholders noted in the first theme of this Briefing Sheet, and to others who have a vested interest in the continued competence of physicians and the safety of patients.

### **Working together is key**

The demand for reentry programs and services for clinically inactive physicians will continue. There also continues to be barriers and challenges to reentry. Determining how to best meet the needs of physicians seeking to reenter clinical practice will take working together by all of the key stakeholders including physicians, regulatory boards, state and medical specialties, insurers, medical schools and others.

## Next Steps

1. Provide a platform for continued information sharing and dissemination of information on physician reentry issues including research and data collection, reentry program information and other related activities. This may include web sites such as [www.physicianreentry.org](http://www.physicianreentry.org) which serves as a non-specialty specific clearinghouse of information from organizations and programs.
2. Encourage the sharing of information on the importance of planning ahead of time for a leave from clinical practice in a wide range of venues including, conferences, state and specialty society communications, medical and specialty board communications, and medical education and continuing medical education programs. Encourage the development and sharing of career planning materials (especially on non-clinical careers) to physicians.

## AMA Council on Medical Education “Re-entry to Medical Practice: Defining the Needs for Medical Education” Panelists:

- Humayun Chaudhry, DO, Federation of State Medical Boards
- Jeffrey Gold, MD, AMA Council on Medical Education
- Eileen Handberg, PhD, University of Florida College of Medicine
- Richard Hawkins, MD, American Medical Association
- Mira Irons, MD American Board of Medical Specialties
- Norman Kahn, MD, Council on Medical Specialty Societies
- William McDade, MD, AMA Council on Medical Education
- Holly Mulvey, MA, American Academy of Pediatrics
- Robert Steele, MD, Coalition for Physician Enhancement

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RESEARCH

Open Access

# A national survey of 'inactive' physicians in the United States of America: enticements to reentry

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## Abstract

**Background:** Physicians leaving and reentering clinical practice can have significant medical workforce implications. We surveyed inactive physicians younger than typical retirement age to determine their reasons for clinical inactivity and what barriers, real or perceived, there were to reentry into the medical workforce.

**Methods:** A random sample of 4975 inactive physicians aged under 65 years was drawn from the Physician Masterfile of the American Medical Association in 2008. Physicians were mailed a survey about activity in medicine and perceived barriers to reentry. Chi-square statistics were used for significance tests of the association between categorical variables and t-tests were used to test differences between means.

**Results:** Our adjusted response rate was 36.1%. Respondents were fully retired (37.5%), not currently active in medicine (43.0%) or now active (reentered, 19.4%). Nearly half (49.5%) were in or had practiced primary care. Personal health was the top reason for leaving for fully retired physicians (37.8%) or those not currently active in medicine (37.8%) and the second highest reason for physicians who had reentered (28.8%). For reentered (47.8%) and inactive (51.5%) physicians, the primary reason for returning or considering returning to practice was the availability of part-time work or flexible scheduling. Retired and currently inactive physicians used similar strategies to explore reentry, and 83% of both groups thought it would be difficult; among those who had reentered practice, 35.9% reported it was difficult to reenter. Retraining was uncommon for this group (37.5%).

**Conclusion:** Availability of part-time work and flexible scheduling have a strong influence on decisions to leave or reenter clinical practice. Lack of retraining before reentry raises questions about patient safety and the clinical competence of reentered physicians.

## Background

Physician reentry first achieved recognition as an important workforce policy issue in 2002, with an article by Mark et al. in which physician reentry was defined as "returning, after an extended absence, to the professional activity/clinical practice for which one has been trained, certified or licensed" [1]. Discussions within the United States of America began among federal policy makers, medical and specialty societies, and educators, leading to the American Academy of Pediatrics (AAP) establishing a multi-organizational Physician Reentry into the Workforce Project (Reentry Project) in 2006. In 2008, the AAP and the American Medical Association (AMA) co-sponsored the Physician Reentry to the

Workforce Conference to identify steps for the implementation of a formal physician reentry system. Both the Reentry Project and the AMA have produced a number of resources that examine issues related to physician reentry [2-4].

Very little data on physician reentry exist. A state-level study by Rimsza in Arizona and a survey of physicians over age 50 by the Association of American Medical Colleges (AAMC) and several specialty societies have provided some important data [5-7]. In addition, Freed et al. conducted studies on clinical inactivity among pediatricians and state medical board licensure policies for active and inactive physicians, reporting that 5% of pediatricians were currently inactive, and 12% had at some point experienced a period of clinical inactivity of 12 months or more [8,9]. Because of numerous data gaps identified by the AAP Reentry Project, a survey

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was fielded in early 2008 on physician reentry into the workforce.

## Methods

A questionnaire (see Additional File 1) was developed using an iterative process with input from members of the AAP Reentry Project Workforce Workgroup and others with expertise in physician workforce issues. Questions were based on those used in the AAMC Survey of Physicians Over 50, conducted in 2006. The Physician Workforce Reentry questionnaire included separate sets of questions for physicians not currently active in medicine and those currently active in medicine. The latter were asked about their experiences leaving and reentering the workforce. Areas of inquiry included reasons for not being active in medicine, planning and experiences related to becoming active again, and several demographic questions.

The questionnaire, with a post-paid return envelope, was mailed to a random sample of 4975 out of 14 113 inactive physicians under the age of 65 years drawn from the Physician Masterfile of the American Medical Association (AMA). The Physician Masterfile is a repository of current and historical information on over 1 million physicians in the United States. The Masterfile is used for AMA membership purposes (although not all physicians in the Masterfile are AMA members) as well as for medical credentials verification, and thus keeping the information current is an ongoing activity. The 'inactive' category in the Masterfile includes individuals who work less than 20 hours per week and report that they are retired, semi-retired, temporarily not in practice or not active for other reasons ('active' physicians are those who report being in direct patient care, or in medical education, research, administration or other medical activities, and work more than 20 hours total per week in those activities). Physicians living outside of the United States were not included in the sample. Respondents were offered a small incentive for prompt return of the questionnaire at each of three rounds (a drawing for gift certificates) in January, February and March 2008.

Data were analyzed using the Statistical Package for the Social Sciences, v. 16. A chi-square statistic was used to test for the significance of the association between categorical variables in contingency tables. T-tests were used to test the significance of differences between means. The Institutional Review Board of the AAP judged this study exempt.

## Results

After three mailings, a total of 1576 completed surveys were returned. Another 613 surveys were returned marked "deceased" or with bad addresses. The adjusted

response rate was 36.1% (1576/4362). Females (42.2%, vs. 32.8% for males,  $P < 0.001$ ), those over age 60 (38.4%, vs. 34.6% for under 60,  $P < 0.01$ ), and those with addresses in the Midwest or West of the United States (40.3% Midwest; 39.8% West; 34.5% South; 30.1% Northeast;  $P < 0.001$ ) all had somewhat elevated response rates.

Respondents were asked, "Are you currently active in medicine?" and were provided examples of activity in medicine (providing clinical services, conducting medical research, medical teaching, health-care administration, and other professional medical activities). Responses that could be selected were: currently active in medicine; fully retired from medicine; not currently active in medicine; and never active in medicine. Although members of the sample were identified as "inactive" at last entry into the Masterfile, 584 (37.0%) reported they were currently active in medicine at the time of our survey, and of these, 358 reported that they had not taken a leave from medicine of 6 months or more. These latter respondents may have been among those who were coded as "inactive" because they had indicated they were semi-retired, or temporarily not in practice at the time of their last AMA census response but may have been working in, for example, medical education (although fewer than 20 hours per week). We excluded them from the analysis, as, for our purposes, they had never been not active in medicine. We included the remaining 226 currently active respondents who reported that they had at some point taken a leave of six months or more from active medicine, and had then reentered medicine. Nine respondents were excluded because they reported they had never been active in medicine, and 47 were excluded for failing to answer the screening question, "Are you currently active in medicine?" This left a final sample of 1162 physicians, divided into three groups: 436 (37.5%) fully retired, 226 (19.4%) reentered, and 500 (43.0%) not currently active.

Table 1 reports characteristics of respondents by status. As expected, the fully retired group was older than both of the other two groups. This group also included the lowest proportion of females. Respondents were predominantly married (77.8%), white (86.2%) and of non-Hispanic ethnicity (95.8%). The reentered group was more likely to report excellent or very good health status (75.6% vs. 58.9%, retired, and 59.3%, inactive). The reentered and fully retired groups reported somewhat better financial health than those not currently active. There were no significant differences between the groups for location of medical school (89.4% United States) or for board certification rate (36.5%) (data not shown). The fully retired group had proportionately more general surgeons and physicians in other surgical specialties, while the reentered group had more

**Table 1 Characteristics of fully retired, reentered and not currently active respondents**

	Fully Retired (n = 436)	Reentered (n = 226)	Not currently active (n = 500)	All respondents (n = 1162)
Age, mean, yrs <sup>a</sup>	60.1 % (n)	54.9 % (n)	55.4 % (n)	57.1 % (n)
Gender <sup>a</sup>				
Female	31.6 (137)	50.4 (114)	49.38 (248)	43.1 (499)
Male	68.4 (296)	49.6 (112)	50.2 (250)	56.9 (658)
Marital status				
Married/partnered	80.5 (347)	78.2 (176)	75.2 (373)	77.8 (896)
Divorced/separated	10.2 (44)	12.4 (28)	11.1 (55)	11.0 (127)
Widowed	1.9 (8)	1.8 (4)	3.2 (16)	2.4 (28)
Single	7.4 (32)	7.6 (17)	10.5 (52)	8.8 (101)
Race				
White	88.9 (378)	86.8 (191)	87.5 (426)	86.2 (1276)
Asian	4.5 (19)	6.4 (14)	5.1 (25)	5.1 (58)
All others	6.6 (28)	6.8 (15)	7.4 (36)	7.0 (79)
Hispanic origin				
Yes	4.5 (19)	3.2 (7)	4.3 (21)	4.2 (47)
Overall health status <sup>a</sup>				
Excellent	35.3 (151)	38.2 (86)	35.6 (177)	36.0 (414)
Very good	23.6 (101)	37.3 (84)	23.7 (118)	26.3 (303)
Good	17.5 (75)	17.3 (39)	20.7 (103)	18.9 (217)
Fair	18.2 (78)	6.2 (14)	13.9 (69)	14.0 (161)
Poor	5.4 (23)	0.9 (2)	6.0 (30)	4.8 (55)
Current financial status <sup>a</sup>				
Excellent	29.8 (127)	29.5 (66)	25.2 (124)	27.7 (317)
Very good	30.3 (129)	28.6 (64)	24.3 (120)	27.4 (313)
Good	25.4 (108)	25.0 (56)	29.0 (143)	26.9 (307)
Fair	13.1 (56)	13.4 (30)	13.2 (65)	13.2 (151)
Poor	1.4 (6)	3.6 (8)	8.3 (41)	4.8 (55)
Primary specialty/subspecialty <sup>a</sup>				
Family medicine	15.0 (57)	17.1 (36)	17.6 (79)	16.5 (172)
Pediatrics	8.7 (33)	7.1 (15)	14.0 (63)	10.7 (111)
Internal medicine	9.5 (36)	20.0 (42)	13.6 (61)	13.4 (139)
Ob-gyn	10.8 (41)	7.6 (16)	8.0 (36)	8.9 (93)
General surgery	7.1 (27)	1.4 (3)	3.1 (14)	4.2 (44)
Other medical specialty	29.5 (112)	36.2 (76)	32.7 (147)	32.2 (335)
Other surgical specialty	19.5 (74)	10.5 (22)	11.1 (50)	14.0 (146)

<sup>a</sup>P < 0.001.

internists, and the not currently active group had more pediatricians.

Table 2 reflects the current experience and status of respondents not currently in the workforce. Over half of those who are fully retired (59.9%) or currently inactive (62.4%) reported last being active in medicine five or more years previously. More of the not currently active group (27.1%) are currently working in non-medical fields than of the fully retired group (16.9%), but substantial majorities of both groups did not report working in another field. The majority (71.2%) of those who are

fully retired reported they have no future plans to become active in medicine; of those not currently active in medicine, 55.3% were “not sure” about plans to return. A large majority of both groups reported retaining at least some medical licenses, although the fully retired respondents were somewhat more likely to report that they had not retained any licensure. Among those with specialty or subspecialty certification, similar majorities reported that their certifications were current. Only a minority had retained any medical liability insurance, and this was almost always tail coverage only.

**Table 2 Physicians who are fully retired or not currently active in medicine (N = 936)**

	Fully retired (n = 436)	Not currently active (n = 500)
	% (n)	% (n)
How long since last active in medicine <sup>a</sup>		
Less than 1 year	3.2 (14)	6.7 (33)
1-2 years	15.9 (69)	11.8 (58)
3-4 years	21.0 (91)	19.1 (94)
5-10 years	38.7 (168)	38.3 (189)
More than 10 years	21.2 (92)	24.1 (119)
<i>missing</i>	(2)	(7)
Currently working in other field <sup>b</sup>		
Yes	16.9 (73)	27.1 (135)
<i>missing</i>	(4)	(1)
Plan to become active in future <sup>b</sup>		
Yes, within a year	1.9 (8)	11.1 (55)
Yes, in one to five years	0.9 (4)	11.5 (57)
Yes, more than five years from now	0.2 (1)	1.0 (5)
No	71.2 (307)	21.1 (105)
Not sure	25.8 (111)	55.3 (275)
<i>missing</i>	(5)	(3)
Retained medical licenses <sup>b</sup>		
Yes, all of them	47.1 (204)	59.6 (297)
Yes, but not all	19.9 (86)	20.5 (102)
No	33.0 (143)	19.9 (99)
<i>missing</i>	(3)	(2)
Specialty/subspecialty board certification(s) current		
Yes, all of them	56.1 (242)	54.9 (272)
Yes, but not all	3.0 (13)	5.3 (26)
No	27.1 (117)	24.4 (121)
Not certified	13.7 (59)	15.4 (76)
<i>missing</i>	(5)	(5)
Retained medical liability insurance <sup>a</sup>		
Yes, tail coverage only	31.6 (136)	24.5 (121)
Yes, full liability coverage	1.6 (7)	2.0 (10)
No	65.6 (282)	69.6 (344)
Other	1.2 (5)	3.8 (19)
<i>missing</i>	(6)	(6)

<sup>a</sup>P <.05.

<sup>b</sup>P <.001.

Fully retired respondents were slightly more likely to report retaining tail coverage.

Those who have reentered active medicine reported a mean of 40.6 hours worked per week. Among these respondents, the average length of time they had been away from active medicine was 4.3 years (not shown).

Table 3 reports the reasons that respondents retired or became inactive. The most frequently cited reason for being fully retired or not currently active in medicine was personal health issues (37.8% for both groups); this reason was frequently cited among those who had reentered active medicine as well (28.8%), second only to the need to care for young children (29.6%). Substantial proportions of

both fully retired (27.8%) and not currently active (21.4%) physicians cited rising medical malpractice premiums as a reason for leaving active medicine; this was the reason for a substantially smaller proportion of those who had reentered (13.7%). Fully retired physicians were more likely to cite 'hassle factors' (37.4%) and insufficient reimbursement (20.6%) as reasons for leaving medicine. Those not currently active were more likely than the other physicians to cite the need to care for other family members (15.2%).

Reasons for becoming active again are shown in Table 4. Responses were significantly different between those who were fully retired and those who were not currently active; the leading response among the former

**Table 3 Reasons not currently active or reason became inactive (before reentry)<sup>a</sup>.**

	Fully retired (n = 436)	Not currently active (n = 500)	Reentered (n = 226)
	Reason not currently active		Reason was inactive <sup>b</sup>
	% (n)	% (n)	% (n)
Personal health issues/concerns	37.8 (165)	37.8 (189)	28.8 (65)
"Hassle factor" (ex: paperwork, compliance issues) <sup>d</sup>	37.4 (163)	28.2 (141)	21.7 (49)
Rising medical malpractice premiums <sup>c</sup>	27.8 (121)	21.4 (107)	13.7 (31)
Lack of professional satisfaction	25.2 (110)	22.2 (111)	19.9 (45)
On call responsibility	19.0 (83)	17.6 (88)	11.9 (27)
Insufficient reimbursement rates <sup>c</sup>	20.6 (90)	15.0 (75)	14.6 (33)
Pursuing a non-medical career <sup>c</sup>	12.2 (53)	17.8 (89)	6.6 (15)
Need to care for young children <sup>e</sup>	6.4 (28)	18.4 (92)	29.6 (67)
Practice not economically viable	12.8 (56)	11.8 (59)	10.6 (24)
Improvement in personal/family finances	13.1 (57)	9.2 (46)	7.1 (16)
Need to care for other family member(s) <sup>e</sup>	5.5 (24)	15.2 (76)	6.6 (15)
Hard to keep up with clinical advances	5.5 (24)	5.0 (25)	0.4 (1)
Inadequate practice volume	2.8 (12)	2.0 (10)	0.4 (1)
Other	24.5 (107)	9.4 (147)	32.3 (73)

<sup>a</sup>Positive responses; multiple response permitted.

<sup>b</sup>No statistics testing of reentered vs. other groups (questions are different).

<sup>c</sup>P < 0.05, fully retired vs. not currently active.

<sup>d</sup>P < 0.01, fully retired vs. not currently active.

<sup>e</sup>P < 0.001, fully retired vs. not currently active.

**Table 4 Reasons to consider becoming active in medicine again or reason reentered<sup>a</sup>**

	Fully retired (n = 436)		Not currently active (n = 500)		Reentered (n = 226)	
	Reasons to consider reentry		Reasons for Reentry <sup>b</sup>			
	%	(n)	%	(n)	%	(n)
Nothing <sup>e</sup>	34.2	(149)	3.6	(18)		
Reasons among those who did not indicate "nothing" would lead them to consider reentry		(n = 287)		(n = 482)		
Availability of part-time work or flexible scheduling <sup>c</sup>	42.5	(122)	51.5	(248)	47.8	(108)
Financial need	43.9	(126)	43.4	(209)	32.3	(73)
Desire to provide volunteer services	40.8	(117)	39.6	(191)	8.0	(18)
Change in family or personal circumstances <sup>e</sup>	30.1	(89)	42.9	(207)	31.0	(70)
Responding to a need in the community	33.1	(95)	38.0	(183)	16.8	(38)
Miss caring for patients <sup>c</sup>	29.3	(84)	37.3	(180)	32.7	(74)
Miss colleagues/practice environment	19.9	(57)	23.4	(113)	22.6	(51)
Want to pursue a new challenge or new area of medicine <sup>e</sup>	10.5	(30)	21.0	(101)	16.8	(38)
Boredom/Too much free time on my hands	12.9	(37)	17.6	(85)	13.3	(30)
An opportunity to change my specialty/subspecialty with relative ease <sup>d</sup>	8.0	(23)	15.6	(75)	9.7	(22)
An opportunity with less administrative responsibility	7.3	(21)	8.3	(40)	10.6	(24)
Other	22.0	(63)	25.7	(124)	19.0	(43)

<sup>a</sup>Positive responses; multiple response permitted.

<sup>b</sup>No statistical testing of reentered vs. other groups (questions are different).

<sup>c</sup>P < 0.05, fully retired vs. not currently active.

<sup>d</sup>P < 0.01, fully retired vs. not currently active.

<sup>e</sup>P < 0.001, fully retired vs. not currently active.

group (34.2%) was that “nothing” would lead them to consider becoming active in medicine again. However, when we exclude those who responded that “nothing” would lead them to consider returning to active medicine, the appeal of many of the remaining reasons to return was very similar for the two groups. The most common response among those not currently active was that availability of part-time work or flexible scheduling (51.1%) would lead them to consider becoming active in medicine again; this was also a common, but less frequent, response among those who were fully retired (42.5%,  $P < 0.05$ ). The availability of part-time work or flexible scheduling was also, by far, the most commonly cited reason for becoming active again among those who had reentered (47.8%).

Nearly a quarter (23.7%) of the fully retired respondents had explored becoming active in medicine again; respondents who were not currently active were twice as likely (50.3%) to report having explored returning to medicine (Table 5). Both groups had used similar strategies to explore reentry, and over 80% of both groups felt that it would be difficult. Of those who had reentered active medicine, slightly more than a third (35.9%) reported that it was difficult to reenter. All three groups were likely to identify limited opportunities for part-time or flexible work schedules as a barrier to reentry. Only 37.5% of the reentered group had retraining before entering practice again. Those who had retraining were, on average, out of the workforce significantly longer than those who did not (6.1 years vs. 2.9 years,  $F = 28.56$ ,  $P < 0.001$ ; not shown). Very few of those who reported receiving retraining had been involved in what might be described as formal training for reentry; seven had been in a reentry program, and five were in mini-residencies. Many more used continuing medical education, either online (15.9%) or live (22.1%), as their reentry educational program.

#### Gender analysis

Additional analyses were performed to examine possible gender differences in family and work responsibilities of our respondents. Table 6 presents the reasons for leaving active medicine for those not currently active and those who have reentered active medicine. Among those not currently active, the most striking differences are the much higher proportions of women who indicate the need to care for young children (35.5% vs. 1.6%,  $P < 0.001$ ) or for other family members (23.4% vs. 7.2%,  $P < 0.001$ ) as to why they left active practice. Among those who have reentered active practice, men are more likely to report reasons for leaving related to the structure and practice of medicine (‘hassle factor’, malpractice premiums, lack of professional satisfaction, insufficient reimbursement, practice not viable) and

women to report family needs (care for young children, care for other family members). Overall, characteristics of the practice environment were cited infrequently as a reason for leaving among women who have reentered, especially in comparison to men of either group, but also compared to women who are currently inactive.

Both female and male physicians who are not currently active in medicine report diverse reasons that might lead them to consider becoming active in medicine again (Table 7). Women were significantly more likely than men to report availability of part-time work or flexible scheduling (57.7% vs. 41.6%,  $P < 0.001$ ) and a change in family or personal circumstances (53.2% vs. 30.0%,  $P < 0.001$ ) as reasons to consider becoming active again. However, among those who have reentered, missing colleagues is also a reason more likely to be reported by female respondents (28.1% vs. 17.0%,  $P < 0.05$ ). Men were significantly likely to report reentering to pursue a new challenge (24.1% vs. 9.6%,  $P < 0.001$ ) or an opportunity with less administrative responsibility (16.1% vs. 5.3%,  $P < 0.01$ ).

#### Discussion

Concerns have been raised over the last several years about a current or impending physician workforce shortage within the United States [10-12]. The potential of inactive or retired physicians to fill a workforce gap has not yet been adequately explored. The cost of mobilizing this ‘shadow workforce’ of physicians, either in a long-term capacity or to respond to an acute health emergency (e.g. a bioterrorist attack, pandemic, or natural disaster), is likely to be significantly less than that of expanding medical school class sizes and residency training slots. It would also be more efficient, as the timeframe for a reentry training program (variable from program to program) is substantially shorter than for training new physicians from scratch. Reincorporating these physicians into the active workforce would allow the public to benefit from their clinical knowledge and experience and recuperate its financial investment in the initial training of these physicians.

In this study of inactive physicians younger than age 65, the average length of time away from medicine for reentered physicians was 4.3 years. However, over 60% of the currently inactive and retired physicians had been out of medicine 5 or more years, including a fifth to a quarter for more than 10 years. Less than a quarter of currently inactive physicians had firm plans to reenter. Over two thirds of retired physicians and 80% of inactive physicians kept at least one medical license, although this may be relatively easy to achieve as there are few states that require measures of clinical activity to maintain licensure [9].

**Table 5 Efforts to reenter active medicine, not currently active and reentered physicians (n = 1162)**

	Fully retired (n = 436)		Not currently active (n = 500)		Reentered (n = 226)	
	%	(n)	%	(n)	%	(n)
Ever explored becoming active in medicine again <sup>a</sup>						
Yes	23.7	(101)	50.3	(237)		n/a
missing		(9)		(23)		
How explored becoming active in medicine <sup>b</sup> (n = 341)						
Did some reading about the process or requirements	28.7	(29)	38.3	(92)		n/a
Talked to professional colleagues	51.5	(52)	45.8	(110)		n/a
Contacted state about licensing	25.7	(26)	27.9	(67)		n/a
Contacted Specialty Board about recertification <sup>c</sup>	2.0	(2)	9.2	(22)		n/a
Contacted a medical liability insurance company regarding a new policy	8.9	(9)	13.8	(33)		n/a
Talked to potential employers	41.6	(42)	40.4	(97)		n/a
Contacted medical school	12.9	(13)	7.5	(18)		n/a
Other	27.7	(28)	22.9	(55)		n/a
Easy or difficult to reenter medicine						
Easy	17.0	(16)	16.5	(36)	64.1	(141)
Difficult	83.0	(78)	83.5	(182)	35.9	(79)
Barriers identified <sup>b</sup> (n = 341)						
State licensure requirements	28.7	(29)	30.0	(72)	17.7	(40)
Specialty Board recertification requirements	10.9	(11)	15.4	(37)	3.8	(22)
Insurance company requirements	29.7	(30)	26.7	(64)	22.1	(50)
Employer requirements	20.8	(21)	20.4	(49)	13.3	(30)
Restrictions on hospital privileges	14.9	(15)	20.8	(50)	11.9	(27)
Limited opportunities for retraining	31.7	(32)	40.4	(97)	15.9	(36)
Cost of retraining	27.7	(28)	23.8	(57)	8.4	(19)
Limited opportunities for part-time or flexible work hours	44.6	(45)	42.5	(102)	26.1	(59)
Family constraints	10.9	(11)	16.7	(40)	10.6	(24)
Other barriers	26.7	(27)	35.0	(84)		
No barriers		n/a		n/a	32.3	(73)
Had retraining before reentering medicine						
Yes		n/a		n/a	37.5	(84)
Retraining experience						
Formal reentry program		n/a		n/a	3.1	(7)
Mini-residency		n/a		n/a	2.2	(5)
Federal Medical Reserve Corps		n/a		n/a	0	(0)
Shadowing an active physician		n/a		n/a	10.6	(24)
Online continuing medical education		n/a		n/a	15.9	(36)
Live continuing medical education		n/a		n/a	22.1	(50)
Other		n/a		n/a	15.5	(35)

<sup>a</sup>  $P < 0.001$ , fully retired vs. not currently active.

<sup>b</sup> positive responses; multiple response permitted.

<sup>c</sup>  $P < 0.05$ , fully retired vs. not currently active.

Given the amount of time out of practice for some of these physicians, formal training in any reentry pathway, if so chosen, is critical. In the last 10 years, major developments in pharmacology, surgical procedures, medical technology, coding, patient privacy, quality improvement—to name just a few—have dramatically altered practice. Increasing demands from the public for documentation of competence will have to be addressed,

particularly considering only 37.5% of reentered physicians reported having any retraining before returning to practice. Freed et al. found that pediatricians who had been clinically inactive were less likely compared to those who had been continuously active to agree that a formal reentry program be required after an absence of 2 years [8]. Although this could be the result of overconfidence in one's ability, this could also reflect the

**Table 6 Reasons left active medicine for those not currently active and those who have reentered, by gender<sup>a</sup>**

	Not currently active <sup>b</sup>				Reentered			
	Female (n = 248)		Male (n = 250)		Female (n = 114)		Male (n = 112)	
	%	(n)	%	(n)	%	(n)	%	(n)
Personal health issues/concerns	34.3	(85)	41.2	(103)	26.3	(30)	31.3	(35)
'Hassle factor' (ex: paperwork, compliance issues)	27.8	(69)	28.8	(72)	13.2 <sup>d</sup>	(15)	30.4	(34)
Rising medical malpractice premiums	19.8	(49)	23.2	(58)	3.5 <sup>e</sup>	(4)	24.1	(27)
Lack of professional satisfaction	21.8	(54)	22.8	(57)	13.2 <sup>d</sup>	(15)	26.8	(30)
On-call responsibility	19.4	(48)	16.0	(40)	7.9	(9)	16.1	(18)
Insufficient reimbursement rates	13.7	(34)	16.4	(41)	6.1 <sup>e</sup>	(7)	23.2	(26)
Pursuing a non-medical career	14.1 <sup>c</sup>	(35)	21.6	(54)	4.4	(5)	8.9	(10)
Need to care for young children	35.5 <sup>e</sup>	(88)	1.6	(4)	56.1 <sup>e</sup>	(64)	2.7	(3)
Practice not economically viable	13.3	(33)	10.4	(26)	4.4 <sup>d</sup>	(5)	17.0	(19)
Improvement in personal/family finances	9.7	(24)	8.8	(22)	5.3	(6)	8.9	(10)
Need to care for other family member(s)	23.4 <sup>e</sup>	(58)	7.2	(18)	10.5 <sup>c</sup>	(12)	2.7	(3)
Hard to keep up with clinical advances	7.7 <sup>d</sup>	(19)	2.4	(6)	0.9	(1)	0	
Inadequate practice volume	0.8	(2)	3.2	(8)	0		0.9	(1)
Other	25.8	(64)	32.4	(81)	25.4 <sup>c</sup>	(29)	39.3	(44)

<sup>a</sup>Positive responses; multiple response permitted.

<sup>b</sup>Two physicians not currently active in medicine did not report their gender.

<sup>c</sup>P < 0.05, female vs. male within activity group.

<sup>d</sup>P < 0.01, female vs. male within activity group.

<sup>e</sup>P < 0.001, female vs. male within activity group.

difficulty of finding accessible programs. Formal reentry programs are few, and often present financial and geographical barriers, and may likely account for the low incidence of use among survey respondents. Live and online continuing medical education (CME) will,

therefore, need to target the learning needs of inactive and reentering physicians and prepare them to face the challenges of a quickly evolving practice environment. An individualized plan to maintain professional credentials and relationships during inactivity, moreover, may

**Table 7 Reasons to reenter active medicine, by gender<sup>a</sup>**

	Not Currently Active <sup>b</sup>				Reentered			
	Reasons to consider becoming active in medicine again				Reasons reentered active medicine			
	Female (N = 248)		Male (N = 250)		Female (N = 114)		Male (n = 112)	
	%	(n)	%	(n)	%	(n)	%	(n)
Availability of part-time work or flexible scheduling	57.7 <sup>e</sup>	(143)	41.6	(104)	54.4 <sup>c</sup>	(62)	41.1	(46)
Financial need	42.7	(106)	41.2	(103)	28.1	(32)	36.6	(41)
Desire to provide volunteer services	41.5	(103)	35.2	(88)	7.9	(9)	8.0	(9)
Change in family or personal circumstances	53.2 <sup>e</sup>	(132)	30.0	(75)	43.9 <sup>e</sup>	(50)	17.9	(20)
Responding to a need in the community	35.9	(89)	37.6	(94)	12.3	(14)	21.4	(24)
Miss caring for patients	37.1	(92)	34.8	(87)	37.7	(43)	27.7	(31)
Miss colleagues/practice environment	23.4	(58)	22.0	(55)	28.1 <sup>c</sup>	(32)	17.0	(19)
Want to pursue a new challenge or new area of medicine	23.4	(58)	16.8	(42)	9.6 <sup>d</sup>	(11)	24.1	(27)
Boredom/Too much free time on my hands	17.7	(44)	16.4	(41)	12.3	(14)	14.3	(16)
An opportunity to change my specialty/subspecialty with relative ease	21.0 <sup>e</sup>	(52)	9.6	(24)	11.4	(13)	8.0	(9)
An opportunity with less administrative responsibility	5.6	(4)	10.0	(25)	5.3 <sup>d</sup>	(6)	16.1	(18)
Other	23.4	(58)	26.8	(67)	14.9	(17)	23.2	(26)
Nothing	2.8	(7)	4.0	(10)	n/a		n/a	

<sup>a</sup>Positive responses; multiple response permitted.

<sup>b</sup>Two physicians not currently active in medicine did not report their gender.

<sup>c</sup>P < 0.05, male vs. female, within workforce status.

<sup>d</sup>P < 0.01, male vs. female, within workforce status.

<sup>e</sup>P < 0.001, male vs. female, within workforce status.

help physicians who are thinking of leaving the workforce for an extended period to anticipate needs for CME, licensure, board certification, credentialing, networking, and other areas, so that they will be able to return to practice more easily.

A common perception among inactive physicians is that reentry to practice would be difficult. The actual experience may not be so, as a majority of respondents who had reentered did not find the process difficult. Easy access to information on how to return to practice, as well as guidance on how to maintain professional credentials during inactivity, may help to dispel the misconceptions of retired and inactive physicians. Free-response answers on the survey suggest that some inactive physicians perceive the health care system to be too complicated and inflexible to permit them to reenter.

The influence of family responsibilities on the decision to withdraw from clinical practice was particularly felt by female physicians in our study, as found by others [8]. The ability to work part-time or with a flexible schedule was the reason most often cited for being able to reenter by those women who had, and was the most compelling factor that would lead currently inactive women to reenter. The same is true for male physicians, who more often stated they left clinical practice for personal health reasons. The importance of a reduced or flexible schedule for these physicians cannot be overstated. A full one quarter of inactive physicians is working in fields other than medicine, which may be the result of their dissatisfaction with the structure of the current health care system. The 'hassle factor' of practice, rising malpractice premiums, insufficient reimbursement, and professional dissatisfaction were frequently cited by retired and inactive physicians as reasons they left medicine; many of them are now working in areas that, presumably, do not have these negative characteristics. Fewer reentered physicians cited these characteristics as reasons they had initially left medicine. Physicians who choose to return may not have experienced as intensely the hassles of practice—thus their return—or alternatively, have rationalized their return by 'softening' the negative memories of their past practice experience. These physicians are working, on average, 40.6 hours a week, which for many physicians would be a part-time schedule. Such a practice arrangement may serve to reduce the 'pain' of the perceived 'hassles' of the past, and it is clearly more accommodating for those with conflicting family responsibilities. Addressing these structural issues would likely reduce the number of physicians who choose to become inactive in the first place.

Our response rate of 36.1% was low, yet not surprising. Our population of physicians - 'inactives' in the AMA's Physician Masterfile - conjures up a cohort of physicians not highly engaged in medicine, with a

matching lack of interest in a survey about their inactivity. In addition, over 20% of initial respondents considered themselves active in medicine and had not taken a leave from medicine longer than 6 months, suggesting that there is room for interpretation as to what an inactive physician actually is. We do not generalize our findings to all inactive physicians, who are most likely a particularly nebulous group. We do hope that we have provided a useful start at describing a group of physicians who could be encouraged to stay active in the workforce.

## Conclusions

Looking to the future, stakeholders in a stable and robust physician workforce will need to foster flexibility in the health care system, create incentives for physicians to return to practice, and develop resources to facilitate the reentry into the medical workforce. Survey respondents in all categories identified needed improvements in a number of areas, ranging from regulatory requirements—such as state licensure, insurance companies, and employers—to the cost and availability of retraining opportunities and limited opportunities for part-time work and flexible scheduling. It is tempting to speculate on how many of these physicians would have stayed active if part-time or flexible work hours had been available either in practice or in residency. Strategies to retain physicians will, therefore, need to account for the changing demographics of the physician population and their priority to balance their professional and personal lives. Finally, the development and promotion of better educational resources for physicians, especially those that would allow doctors to maintain their professional credentials and access affordable and relevant CME, would enable more predictable departures and reentry. A coordinated and comprehensive agenda that includes educational, research, regulatory and public policy efforts will thus be required to overcome barriers to physician reentry into the medical workforce and to respond effectively to national workforce needs.

## Additional material

**Additional file 1: Physician workforce survey.**

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#### Authors' contributions

EAJ was principal investigator and acquired the funding. EAJ and HRR designed the survey. SEB and HRR acquired the data. HRR analyzed the data and all three authors interpreted the data, wrote the manuscript, and approved the final version.

#### Competing interests

The authors declare that they have no competing interests.

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2010

## **Pediatricians Over 50 Reentering Clinical Practice**

Implications for Physicians and  
the Regulatory Community

### ALSO IN THIS ISSUE

---

**Telemedicine:  
Finding the Balance**

.....

**Maintenance of  
Licensure:  
Protecting the Public,  
Promoting Quality  
Health Care**

.....

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VOLUME 96, NUMBER 2, 2010

WHAT IS DRIVING PHYSICIAN  
REENTRY DECISIONS, AND IS  
OUR CURRENT SYSTEM  
ADEQUATELY DESIGNED  
TO HANDLE THE  
REENTRY PROCESS?

**2** Publisher's Information

.....

**3** Quoted | Note from the Editorial Committee

.....

**4** Message from the Chair

.....

**7** **Pediatricians Over 50 Reentering  
Clinical Practice: Implications for  
Physicians and the Regulatory Community**

Holly J. Mulvey, M.A.

Ethan Alexander Jewett, M.A.

Alicia Merline, Ph.D.

Kelly J. Towey, M.Ed.

.....

**13** **Maintenance of Licensure: Protecting the  
Public, Promoting Quality Health Care**

Humayun J. Chaudhry, D.O.

Janelle Rhyne, M.D.

Frances E. Cain

Aaron Young, Ph.D.

Martin Crane, M.D.

Freda Bush, M.D.

.....

**21** International Briefs



**24** State Member Board Briefs



**30** Information for Authors



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## **The perfect journey is circular — the joy of departure and the joy of return.**

— Dino Basili

THE PACE AND DEMANDS of a life in medicine can be daunting—just ask anyone who has tried to juggle the responsibilities of both a clinical practice and raising a family. For some, it’s simply not possible, and that’s why it’s not uncommon for young female physicians to temporarily leave practice when they start having children. After a few years, many will come back to medicine—and that’s when issues of education, training and licensure arise. How can we be sure that a practitioner is still sharp and up to speed on clinical matters after years of inactivity? The general topic—known as “physician reentry”—covers much more than absence due to child rearing, of course, with reasons for leaving and returning to medicine widely variable, and applicable to both men and women. [In this issue of the \*Journal of Medical Regulation\*, we feature a study from the American Academy of Pediatrics that considers the regulatory implications of reentry in just one slice of the physician community: pediatricians who are age 50 and over \(page 7\).](#) We believe that many conclusions from this study could be applied to the overall physician population, which shares many of the traits of this demographic group. It could reasonably be assumed that physicians in most specialties would experience many of the same reasons for leaving the workforce and the same reentry challenges as pediatricians. We need new research and resources to address this issue, and many institutions are beginning to provide them: Drexel University and the Center for Personalized Education for Physicians are just two examples of innovative physician reentry programs. But state medical boards have a role to play, too: We must vigilantly monitor our policies to make sure they accurately address the various implications of physician reentry. If anything, it will only become more common in the future. (A special note: After great service to the *Journal*, former editor Bill Wargo has resigned his post. We’ll miss Bill’s talents and leadership; in the meantime, the search is under way for a successor.)

### **Editorial Committee**

*Journal of Medical Regulation*

# Finding the Balance: As Telemedicine Evolves, So Too Should Our Policy Engagement

Freda Bush, M.D., FACOG  
Chair, Board of Directors  
Federation of State Medical Boards

**IN BRIEF** Dr. Bush examines the growth of telemedicine and its impact on the regulatory community, calling for vigilance and leadership by state medical boards.

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Telemedicine — which has often been thought of in futuristic terms — is rapidly becoming a part of our day-to-day work in medicine. From the transmission of radiological images back and forth internationally to the use of wireless technology in monitoring vital signs in our patients, the medical community is becoming increasingly comfortable with the idea of “virtual” medical transactions.

But we’re a long way from having a true interstate telemedicine “system” in the United States — especially in terms of consistent practice guidelines and regulatory policy.

Bringing the growing practice of telemedicine into alignment with a sensible policy that helps shape and define it for the future is an issue that falls squarely into the laps of medical regulators. Some of the most fundamental questions still to be sorted out regarding telemedicine revolve around the licensing and disciplining of physicians and how to ensure patient protection.

Recognizing this need, FSMB is planning to convene a meeting of telemedicine stakeholders early in 2011 to focus on these questions. The FSMB Board of Directors has agreed that it is important for FSMB to play a leadership role in helping to shape a discussion of how we can accommodate the new and developing technologies of telemedicine while protecting the public we serve. State medical boards must have a prominent voice in the national discussion of telemedicine.

### **Telemedicine: The Growth to Come**

The statistics on telemedicine paint a clear picture: A United States Commerce Department summary

published in 2009 reported that the market for telemedicine devices and services is likely to exceed \$1.8 billion by 2013.<sup>1</sup> The market is expected to grow by more than 50 percent annually in years to come.<sup>2</sup>

According to the American Telemedicine Association, an estimated 80,000 homes have been wired for remote health care monitoring,<sup>3</sup> and some of the largest and most recognizable names in U.S. industry are aggressively diving into the market. GE Healthcare, Microsoft and other major players recognize the opportunities in digital health care and are busily developing new products.

Hospital-based centers of innovation are springing up around the country, and drawing attention. A *New York Times* special report focused recently on mobile medical robots, for example, which are now being used in hundreds of hospitals to make it possible for off-site physicians to interact with patients.<sup>4</sup>

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**SOME OF THE MOST FUNDAMENTAL QUESTIONS TO BE SORTED OUT REGARDING TELEMEDICINE REVOLVE AROUND THE LICENSING AND DISCIPLINING OF PHYSICIANS AND HOW TO ENSURE PATIENT PROTECTION.**

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These developments are not occurring in a vacuum: There are strong factors at play, compelling the emergence of a telemedicine market. Among them:

- A significant increase in the growth of the U.S. population, matched with an expected shortage of physicians to serve them.
- The growing incidence of chronic disease in aging populations and the growing number of elderly, home-bound, physically challenged patients.

- A growing emphasis on the use of technology to improve patient safety.
- A lack of physicians — and of medical specialists — in rural and underserved areas.
- The cost crisis in health care — and the need to find ways to deliver care more efficiently.
- Incentives in the recently passed health reform legislation intended to accelerate the use of health information technology.

Despite all of this, telemedicine faces significant challenges. At the top of the list are concerns from patients about safety and privacy, the potential impact on the traditional patient-physician relationship and a lack of strategic alignment between the government and the private sector.

Many practical issues remain insufficiently addressed, including reimbursement policies of third-party payers, the establishment of interoperability between medical devices and the development of a robust national digital infrastructure from which telemedicine could be more universally launched.

Thorny policy issues also lie ahead. How do we define medical liability and malpractice? How do we ensure that telemedicine's costs and benefits are distributed equitably? And of course, the biggest issue for medical regulators: How do we sort out the licensing process?

### **FSMB's Role in the Telemedicine Discussion**

As telemedicine has evolved over the past several decades, FSMB has attempted to capture its transformational promise, while maintaining a vigilant watch on its ramifications in terms of physician licensure and patient safety. One of the first issues it began monitoring was the question of how telemedicine's reach across state lines could be reconciled in a state-by-state regulatory system.

In 1996, the FSMB House of Delegates approved *A Model Act to Regulate the Practice of Medicine Across State Lines*. This model act provided medical boards with the foundation from which to effectively regulate the medical practice of those physicians interested in multi-state practice, while protecting the health and safety of patients.

In 2002, FSMB continued its work in this arena with *Model Guidelines for the Appropriate Use of the Internet in Medical Practice*, spurred in part by

the growth of Internet pharmacies. These guidelines crafted a balance between the benefits and drawbacks of using the Internet in the practice of medicine.

More recently, the FSMB House of Delegates adopted a resolution proposed by the Iowa Board of Medicine in 2007 recognizing the value of telemedicine technologies in medical practice and recommending that a common and consistent definition of telemedicine be adopted by all member medical boards.

### **The Uniform Application**

In an effort to address one of the most challenging issues in telemedicine — regulation across state lines — FSMB in 2006 launched an initiative to reduce state-line licensure barriers, redundancies and inefficiencies. The resulting FSMB product, known as the Uniform Application for Physician State Licensure, or simply the UA, makes the physician licensing process more portable and more

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THORNY POLICY ISSUES ALSO LIE AHEAD. HOW DO WE DEFINE MEDICAL LIABILITY AND MALPRACTICE? HOW DO WE ENSURE THAT TELEMEDICINE'S COSTS AND BENEFITS ARE DISTRIBUTED EQUITABLY?

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convenient among states. The UA is a Web-based application that standardizes, simplifies, streamlines and improves processing times for state medical boards' licensure applications. It combines a streamlined online license application process with state-specific addendums that enable states to customize the process while retaining the system's overall convenience and efficiency.

Increasing portability via tools such as the UA has the potential to extend the benefits of telemedicine to patients residing in rural or isolated areas, those in need of specialized care, and home-bound or non-English-speaking patients. The UA will also help reduce the structural barriers that inhibit the availability of emergency and specialty physicians across state borders in times of crisis.

### **Protecting the Patient-Physician Relationship**

Among the concerns expressed by some reluctant to adopt telemedicine is the fear that it will dimin-

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ish the quality of medicine by replacing face-to-face interactions between patient and physician. This is, indeed, a vexing question and one that must be addressed.

Organized medicine has traditionally placed great value on the physical exam as an important component of the patient-physician relationship. But in light of recent advances in technology — including robotic devices that connect patients and physicians — increased discussion is needed on how best to define the parameters of what constitutes a patient-physician “relationship.”

In the meantime, it’s a good idea for all of us in the regulatory community to stay familiar with policy best practices when it comes to regulating telemedicine.

FSMB stands firmly on several key principles in defining and protecting the patient-physician relationship in an electronic environment.

These basic concepts can be found in our *Model Guidelines for the Appropriate Use of the Internet in Medical Practice*, available in the “Advocacy and Policy” section of FSMB’s website ([www.fsmb.org](http://www.fsmb.org)):

- Although it may be difficult in some circumstances, particularly in an online setting, to define precisely the beginning of the patient-physician relationship, it tends to begin when an individual seeks assistance from a physician with a health-related matter for which the physician may provide assistance. However, the relationship is clearly established when the physician agrees to undertake diagnosis and treatment of the patient and the patient agrees, whether or not there has been a personal encounter between the physician (or other supervised health care practitioner) and patient.
- Digital medical relationships are acceptable in most states as long as they take place in the context of an established patient-physician relationship.
- A documented patient evaluation must be obtained prior to providing treatment, including issuing prescriptions — electronic or otherwise.
- Treatment and consultation recommendations made in an online setting should be held to the same standards of appropriate practice as those in traditional (face-to-face) settings.

Treatment, including a prescription, based solely on an online questionnaire or consultation does not constitute an acceptable standard of care.

- The use of a questionnaire or only conversing with the patient over the telephone may not constitute a valid patient-physician relationship for prescribing.

More information about FSMB’s 2011 telemedicine forum will be made available in coming months at the FSMB website and in various publications as the planning process moves forward. Meanwhile, state medical boards should stay engaged and focused on this important — and fast evolving — topic.

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# Pediatricians Over 50 Reentering Clinical Practice: Implications for Physicians and the Regulatory Community

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Holly J. Mulvey, M.A., Ethan Alexander Jewett, M.A.,  
Alicia Merline, Ph.D., and Kelly J. Towey, M.Ed.  
American Academy of Pediatrics

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**ABSTRACT:** Physician reentry into the workforce can be defined as returning to professional activity/clinical practice for which one has been trained, certified or licensed after an extended time period away. Little data and information on this topic exist; however, the American Academy of Pediatrics, in conjunction with the Association of American Medical Colleges, sent a survey to 1,600 pediatricians aged 50 and older that included information on extended leaves of absence from clinical practice, retirement patterns, and considerations/preparation to reenter the workforce. Data from this group showed that extended leaves of absence are not tied to generalist or specialist practice, career satisfaction, or desire for a part-time practice arrangement. Women were more likely than men to take extended leaves of absence from clinical medicine, and these leaves were longer than those for men. Additionally, very few reentering pediatricians had any retraining before returning to practice. In the future, policymakers, educators, state medical and osteopathic boards and others will need to collaborate to design a reentry system that addresses physician readiness to return to the workforce — as well as patient safety issues — and to tailor education to the needs and focus of individuals reentering physician's practice.

**Keywords:** reentry, retraining, workforce, leave of absence, pediatrician, state medical and osteopathic boards

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## Introduction

Many physicians leave practice and then wish to reenter the physician workforce after a significant period of time away from clinical medicine. Physician reentry into the workforce can be defined as returning to professional activity/clinical practice for which one has been trained, certified or licensed after an extended time period. This issue, which was first examined in detail by Mark and Gupta in *JAMA* in 2002,<sup>1</sup> cuts across genders and specialties. There are a myriad of stated reasons for leaving and reentering the workforce, ranging from child rearing or caring for elderly relatives to career dissatisfaction and the high cost of medical liability insurance premiums. Another category of reentry physicians includes those who initially retired from practice and later, for reasons ranging from financial to personal preference, seek to return to the workforce.

Reentry is to be differentiated from remediation, which is a disciplinary intervention to address a departure from practice due to a breach of medical ethics, substance abuse, loss of one's medical license, or similar issue. Reentry is also different from retraining, which may not be part of the reentry process, as in the case of physicians who train in a new discipline, such as a subspecialty, without leaving their current practice. Jacoby et al, for example, explored the possibility of retraining specialist physicians to deliver primary care during the managed care push of the mid to late 1990s.<sup>2</sup> There is little information and data on physician reentry in the medical literature. The American Medical Association (AMA) Masterfile notes that in 2008, there were 119,238 inactive physicians in the United States, which accounts for 12% of the 954,224 physicians in the Masterfile.<sup>3</sup> At present, it is unclear how many of these physicians left the workforce with the desire or intention of returning at some point in the future. Those who do wish to

return are likely to face systemic barriers, including educational needs, state licensure, board certification restrictions, financial constraints, and verification of clinical competence. Even physicians who have remained active in the medical profession in research, teaching, or administration are likely to face challenges if they seek to return to clinical practice.

Few state- or specialty-specific studies have been conducted to document the trends of physician reentry, including the reasons and demographic characteristics of those who leave and attempt to reenter the workforce. In a study of Arizona physicians between 2003 and 2006 conducted by Rimsza et al, it was noted that of the 604 physicians reentering clinical practice, 62 (10%) had changed the specialty focus of their practice since the last time they were clinically active. More than half of these physicians changed their specialty designation from obstetrics to gynecology, but there was also some migration among primary care specialties and from primary to subspecialty care.<sup>4</sup>

Public policy discussions have increasingly focused on physician reentry in recent years, because of its impact on many elements of health care, ranging from education to patient safety to the regulatory system. Physicians who exit the workforce represent a loss of the costly public investment in medical education, as well as a loss to the health care system of the clinical and intellectual capital of these physicians. When these physicians seek to return to practice, a host of questions are raised about assessing their clinical competence, their need for some kind of reentry education, the ability of state medical and osteopathic boards to document reentering physicians' readiness to resume practice, and a wide range of liability issues. With no formal or centralized reentry system, however, such questions remain largely unanswered.

## Methods

The American Academy of Pediatrics (AAP), in conjunction with the Association of American Medical Colleges and eight medical associations, conducted a cross-sectional survey examining physician reentry in 2006. Questionnaires were mailed to 1,600 pediatricians aged 50 and over up to three times between February and May of 2006. Members of the AAP Senior Section—which is open to AAP members over the age of 55 (N = 730)—and 870 randomly selected good-standing members of the AAP who were over the age of 55 but not members

of the senior section were surveyed. This project received approval from the Institutional Review Board (IRB) at the AAP. No remuneration was provided to respondents. Valid responses were collected from 72% (N = 1158) of the pediatricians surveyed.

Tests comparing sample respondents with all members in the sample, and comparing sample respondents with all AAP members over the age of 50 revealed that the respondent population is older (mean age = 68) than the AAP over-50 population (mean age = 60) ( $t(23107) = 24.81, p < .000$ ).

The respondents are also more likely to be male (73%) than the target population (66%) ( $\chi^2(1, N = 22917) = 29.47, p < .001$ ). Therefore, sampling

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### PHYSICIANS WHO ARE CONTEMPLATING LEAVING THE WORKFORCE, AS WELL AS THOSE WHO ARE PLANNING TO REENTER CLINICAL PRACTICE, WILL NEED GUIDANCE FROM THEIR STATE MEDICAL AND OSTEOPATHIC BOARD.

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weights were calculated to reflect the appropriate proportional representation of AAP members over the age of 50. These weights were used for all analyses reported here.

This survey asked questions regarding work status, work history, education, and demographic information. Leave of absence was measured by asking respondents whether they ever took a six-month or longer leave of absence from medicine. Those who reported having taken a leave of absence were asked how long it lasted and the reasons for taking a leave. They were also asked whether the leave was to care for children or other family members and whether they received any retraining prior to reentering medicine.

Desire for part-time work was measured by asking respondents whether they would prefer to work part time if part-time hours were available. Respondents rated their satisfaction with medicine as a career on a five-point scale. They were asked to indicate whether they owned their practice and whether they practiced primary care pediatrics or a pediatric medical or surgical subspecialty.

Respondents who reported their current work status as “retired” were asked whether they ever considered reentering medicine, their reasons for considering reentry, and whether they retired earlier than planned or expected.

### Statistical Analyses

A series of t-tests were performed to reveal group differences in extended leave. A series of chi-square comparisons examined group differences in extended leave and reentry. One logistic regression was conducted to predict extended leave taking. For all analyses a p value under .05 was considered statistically significant.

### Results

Overall, 2% of the sample described their current status as “temporarily inactive from medicine,” and 11% reported having taken an extended leave at some point in their career. Length of leave ranged from 6 months to 13 years with an average duration of 22 months and a median duration of 12 months.

Women (23%) were more likely than men (5%) to report that they had ever taken a leave of absence from medicine  $\chi^2(1, N = 1109) = 87, p < .001$ . The average leave was longer for women (27 months) than it was for men (11 months;  $t(104) = 3.953, p < .001$ ).

Taking a leave of absence was less common among practice owners (5%) than among non-owners (15%)  $\chi^2(1, N = 908) = 24, p < .001$ , but was equally as likely for specialists and generalists  $\chi^2(1, N = 1086) = 0, p = .98$ .

These differences remain significant when tested in a multivariate framework. A logistic regression

examined the associations between taking a leave of absence and gender, ownership status and specialist status. As depicted in Table 1, women have higher odds of taking an extended leave, and practice owners have lower odds of taking an extended leave. Of those who took an extended leave of absence, 54% reported that they took time off “to care for children or other family members,” and 23% reported having retrained before reentering medicine.

Women were more likely than men to use their time off for family care  $\chi^2(1, N = 121) = 42, p < .001$ , but were equally as likely as men to retrain prior to reentering medicine  $\chi^2(1, N = 113) = 0.98, p = .321$ .

Pediatricians who reported having taken a leave of absence are not different from other pediatricians over the age of 50 in terms of satisfaction with medicine as a career ( $t(939) = 0.240, p = .810$ ) or in terms of desiring but having no access to part-

PHYSICIANS WHO HAVE LEFT THE WORKFORCE SHOULD BE ENCOURAGED OR REQUIRED TO CONTINUE TO MAINTAIN AND EXPAND THEIR MEDICAL KNOWLEDGE SO AS TO BETTER FACILITATE THEIR RETURN TO CLINICAL PRACTICE.

time hours in their current work setting  $\chi^2(1, N = 883) = 3.13, p = .077$ . Among the retired pediatricians in this sample, 37% expressed interest in reentering medicine. Those who retired earlier than they had planned or expected were more likely to

**Table 1**  
**Logistic Regression Predicting Extended Leave**

Predictor	$\chi^2$	degrees of freedom	p	OR
Constant	114.270	1	0.000	0.088
Female pediatrician	40.524	1	0.000	4.672
Medical-practice owner	21.136	1	0.000	0.290
Pediatric subspecialist	1.440	1	0.230	0.729
<b>Overall model evaluation</b>	<b>73.455</b>	<b>3</b>	<b>0.000</b>	
Likelihood ratio test	519.493			
Wald Test	392.691			

$\chi^2$  = Test of whether the data is distributed differently than would be expected if it were random.

Degrees of freedom (df) = The number of values in the calculation that are free to vary.

p = Probability that the statistical result is invalid.

OR = Odds ratio. The strength of the association between the predictor and the outcome.

express interest in reentering medicine (50%) than those who retired at their planned age or later (30%)  $\chi^2(1, N = 154) = 5.68, p = .022$ . When asked to endorse reasons they considered reentering, retirees selected “miss caring for patients” more than any other reason. Other reasons for interest in reentering among retirees are listed in Table 2.

## Discussion

The data from this survey clarifies a number of trends regarding physician reentry, particularly regarding the demographic attributes of those who take an extended leave of absence. It is logical that practice owners were less likely to take extended leaves of absence than non-owners. Practice owners’ responsibility to attend to the administrative aspects of the practice, provide adequate coverage for service demands, and ensure the continuity and quality of patient care would make it difficult for them to take substantial time away from practice. It is noteworthy, however, that extended leaves of absence were not tied to either generalist or specialist practice, career satisfaction, or the desire for a part-time practice arrangement.

Perhaps most significant for pediatrics are the findings related to gender differences. Data from the American Academy of Pediatrics demonstrates that in 2009 women constituted almost 55% of non-resident pediatrician members. In the same year, approximately 72% of all pediatric residents were women.<sup>5</sup> These are highly significant statistics in light of this survey’s results, which document that women are more likely to take extended leaves of

**POLICYMAKERS AND STATE MEDICAL AND OSTEOPATHIC BOARDS SHOULD EMBRACE THE IDEA THAT LEAVING AND REENTERING THE WORKFORCE IS PART OF MANY PHYSICIANS’ CAREER TRAJECTORIES AND NOT AN ODD OR UNUSUAL SITUATION.**

absence, and that these leaves of absence are longer than those for men. From a workforce perspective, the number of pediatricians required to meet workforce needs will depend on the clinical intensity of those working and the patterns of their exit and reentry into practice.

In order to accommodate the needs of the growing number of women pediatricians, particularly those relating to caring for other family members, it will be

necessary for both pediatric training and practice to become more flexible. In particular, educators, employers, professional associations, and others should develop strategies to assist women pediatricians in continuing at least a minimal level of clinical

**Table 2**  
**Reasons for Interest in Reentering Medicine Among Retired Pediatricians**

Reason	Number
Miss caring for patients	56%
Responding to a need in the community	42%
Miss colleagues/practice environment	38%
Financial reasons	20%
Too much free time on my hands	20%
Want to pursue a new challenge/area of medicine	18%

cal and professional activity while they are caring for family members to obviate the need for a full-scale reentry experience. For those pediatricians who do choose to leave the workforce altogether, resources to help them reenter the workforce will need to be developed and, of greater importance, promoted.

Interest in reentering the workforce, however, is not uniquely related to gender. The survey data also demonstrated that retired physicians were moderately to highly interested in returning to practice. For these physicians, interest in returning to practice was not related to financial need or some other market driver. Vocational or identity issues of being a physician, such as missing caring for patients, wishing to respond to a need in the community, and missing colleagues or the practice environment, proved to be highly determinative in their interest to return to practice. Reentry is, therefore, an issue not only of the public’s or health care system’s investment in the education and formation of the pediatrician, but also of the pediatrician’s investment in the practice of medicine and the provision of patient care. Policymakers and state medical and osteopathic boards should embrace the idea that leaving and reentering the workforce is part of many physicians’ career trajectories and not an odd or unusual situation. Any structured reentry system will, therefore, need to provide a portal for pediatricians who have retired to contribute to the profession and the needs of the pediatric patient population in a meaningful way.

One area of serious concern identified by the survey was the lack of reentry training before returning to practice. This is likely due to the absence of any standardized and accepted reentry pathway, and consequently, the administrative, financial, logistical and other barriers involved in crafting a personally tailored and relevant reentry experience. Nonetheless, this finding is concerning in an era when the public demands accountability for health care quality and safety. This may, in fact, put an additional burden on state medical and osteopathic boards, which, in turn, may need to aggressively develop plans to address reentry issues. Of equal importance, these state boards will need to proactively communicate policies to the physicians in their state. State medical and osteopathic boards could provide easy access to up-to-date information on changes in policies and/or procedures (theirs and possibly those of other regulatory groups in their state) that may affect physicians seeking to reenter the workforce, perhaps by being able to opt-in for electronic alerts when changes occur. Physicians who are contemplating leaving the workforce, as well as those who are planning to reenter clinical practice, will need guidance from their state boards.

This study has several limitations. Because only pediatricians aged 50 or over were surveyed, the gender differences may be greatly reduced for younger generations of pediatricians. Indeed, lifestyle issues may be more determinative for younger generations than the respondents in this study. Professional satisfaction, the clinical demands of subspecialty practice, the desire for part-time practice, and other lifestyle considerations have been demonstrated to be very important to younger physicians. These factors may likely prove to be decisive in the future as reasons for extended leaves of absence.<sup>6</sup>

## Conclusion

The need for physician reentry pathways is apparent as many physicians, including those over the age of 50, choose to leave clinical medicine for a period of time and then desire to reenter clinical practice. It is also clear that different physicians—and indeed, pediatricians—will need different types of education, depending on time away from practice, general versus subspecialty practice, academic versus community-based practice, and other factors. This education will have to meet the

requirements for maintenance of licensure, maintenance of board certification, gaining of hospital privileges, and other regulatory challenges. A growing number of state medical and osteopathic boards, for example, issue limited licenses for physicians who have left the workforce (i.e., clinical practice) and/or have specific rules for physicians seeking to reenter the workforce.<sup>7</sup> For these reasons, medical specialties and their societies, in partnership with state medical and osteopathic boards, will need to play a key role in determining the criteria for specialty-specific competency needs of physicians who desire to reenter clinical practice. They will also need to develop the tools and resources needed to assist these reentry physicians.

State medical and osteopathic boards could serve as the conveners and facilitators of several organi-

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DIFFERENT PHYSICIANS—AND INDEED, PEDIATRICIANS—WILL NEED DIFFERENT TYPES OF EDUCATION, DEPENDING ON TIME AWAY FROM PRACTICE, GENERAL VERSUS SUBSPECIALTY PRACTICE, ACADEMIC VERSUS COMMUNITY-BASED PRACTICE, AND OTHER FACTORS.

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zations and groups (e.g., state medical societies, state hospital associations, and the state chapters of specialty societies) that are all working on various aspects of physician reentry.

The concept of lifelong learning will play an important role in physician reentry. Physicians who have left the workforce should be encouraged or required to continue to maintain and expand their medical knowledge so as to better facilitate their return to clinical practice. For example, Adams et al (2008) described an innovative retraining program to refresh the skills of obstetrician-gynecologists who have taken an extended voluntary leave of absence and wish to return to active clinical practice.<sup>8</sup> State medical and osteopathic boards are in a unique position to collect and share information about “best practices” that will both inform and facilitate the efforts of many.

It is hoped that state medical and osteopathic boards, and indeed, all interested parties, will be willing to move forward to address physician reentry in the face of a paucity of data. As noted earlier, although some studies have been conducted, they

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are certainly not comprehensive. State medical and osteopathic boards are also in a unique position to ameliorate this situation. Working in collaboration with the Federation of State Medical Boards (FSMB) to develop a comprehensive and combined approach, they can collect uniform data across states and over time that will inform the planning at the state level and contribute to a national study of physician reentry.

Developing a standardized reentry pathway that meets diverse needs and situations will pose many challenges and require input and collaboration from a wide range of stakeholders, including reentering physicians, reentry training programs, assessment and evaluation experts, licensing and regulatory authorities, workforce policymakers, and others. This, however, is a challenge that must be met if we wish to ensure public safety and inspire public confidence.

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# Maintenance of Licensure: Protecting the Public, Promoting Quality Health Care

Humayun J. Chaudhry, D.O., Janelle Rhyne, M.D., Frances E. Cain, Aaron Young, Ph.D., Martin Crane, M.D. and Freda Bush, M.D.

**IN BRIEF** The authors describe a system in which physicians periodically demonstrate ongoing clinical competence as a condition of license renewal.

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### Introduction

The practice of medicine in the United States, according to the 2010 edition of *A Guide to the Essentials of a Modern Medical and Osteopathic Practice Act* of the Federation of State Medical Boards (FSMB), is “a privilege granted by the people acting through their elected representatives.”<sup>1</sup> Citing public health, safety and welfare, and the need for protection of the public from the “unprofessional, improper, incompetent, unlawful, fraudulent and/or deceptive practice of medicine,” the *Essentials* document—formally adopted by the FSMB’s House of Delegates—acknowledges the historical and constitutional role of the state medical and osteopathic boards “to provide laws and regulations to govern the granting and subsequent use of the privilege to practice medicine.”

While the granting of the initial privilege to practice medicine is generally viewed as a robust process along a rigorous continuum of medical education encompassing both undergraduate and graduate training, with multiple assessments and decision points that must be cleared along a prescribed pathway, the process for the subsequent use of that privilege has been the focus of increasing commentary and suggestions for improvement. This article summarizes the background and history by which the FSMB adopted, in April of 2010, a seminal policy recommendation outlining a framework by which state medical and osteopathic boards could require physicians with active medical licenses to periodically demonstrate their ongoing clinical competence as a condition for licensure renewal.

### Medical Regulation in Service to the Public

While the earliest instance of medical regulation in the Americas dates to 1649,<sup>2</sup> and the first local government license to practice medicine was adopted in 1760 in New York City,<sup>3</sup> the authority of state governments to regulate health care in the United States dates to the adoption, in 1791, of the 10th Amendment to the Constitution: “The powers not delegated to the United States by the Constitution, nor prohibited by it to the states, are reserved to the states respectively, or to the people.”

Some states initially gave local medical societies the power to examine and license prospective doctors,<sup>4</sup> while others bestowed such a right to medical schools. The notion that medical licensure and discipline should best be regulated by state-appointed licensing boards, the majority of whom today include public members on their voting bodies, rather than medical societies (which ostensibly represent the interests of practicing physicians) or medical schools took several decades to gain traction. It has been postulated that what ultimately caused medical regulation, alongside coincidental public health legislation, to flourish between 1850 and 1900 was a combination of two factors: a failure of pure free-enterprise theory and the contribution of science.<sup>5</sup> While “good” goods, like “good” doctors, should have ultimately driven out “bad” ones in a free market, a better informed public was no longer willing to wait that long; people also became aware of the fact that danger lurked in bad food and bad water, an awareness prompted by the discovery of germs, that prompted calls from many corners for better protection from poor sanitation as well as from “bad” doctors.

The FSMB, since its establishment in 1912 as the umbrella organization for all state medical and osteopathic licensing boards in the United States and its territories, has actively promoted or supported during its long history such activities as stronger entrance criteria for medical schools,

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improvements in undergraduate medical education, closure of underperforming medical schools following the 1910 Flexner Report, passage of state medical practice acts, the formation of the American Board of Medical Specialties (ABMS) and the Educational Commission for Foreign Medical Graduates and, in 1991, the creation — in partnership with the National Board of Medical Examiners (NBME) — of the United States Medical Licensing Examination (USMLE). Physicians with the D.O. (doctor of osteopathic medicine) degree typically take the Comprehensive Osteopathic Medical Licensing Examination (COMLEX-USA) of the National Board of Osteopathic Medical Examiners (NBOME).

The FSMB, as stated in its current mission statement, seeks to lead by “promoting excellence in medical practice, licensure, and regulation as the national resource and voice on behalf of state medical boards in their protection of the public.” The FSMB has more recently served the public and its 70 state medical and osteopathic boards through the development of a national database of licensed

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**ADOPTION OF AN MOL FRAMEWORK BY THE FSMB, WITHIN THIS CONTEXT, IS CONSISTENT WITH STATE BOARDS’ DESIRE TO PROTECT THE PUBLIC AND PROMOTE QUALITY HEALTH CARE WITH ROBUST STANDARDS FOR PHYSICIAN LICENSURE.**

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physicians and physician assistants, a disciplinary alert service, a Federation Credentials Verification Service (FCVS) and a Uniform Application to speed state processing of licensure applications and facilitate license portability without infringing the states’ autonomy or rights. Adoption of a Maintenance of Licensure (MOL) framework by the FSMB, within this context, is consistent with state medical and osteopathic boards’ desire to protect the public and promote quality health care with robust standards for physician licensure.

**Medical Regulation to Promote Health Care Quality**

Significant technological and scientific advancements have been pioneered by physicians and scientists in the United States but there are several reasons why we do not have the very best health care system in the world (e.g., insufficient access to primary care services, a lack of coordination of

health care delivery, defensive medicine practices) despite all of our expenditures.<sup>6,7</sup> The quality of the health care that is delivered is an area of inquiry that has garnered great attention in the last two decades. These analyses have sometimes offered specific recommendations to medical educators, health care leaders, medical regulators and federal and state government officials to help reform the health care workforce, decrease medical errors and promote best practices among health care providers. Many of these reports have also made specific recommendations about the standards and practices for renewal of medical licenses.

In 1995, the Pew Charitable Trust Health Professions Commission recommended that states “require each licensing board to develop, implement and evaluate continuing competency requirements to assure the continuing competence of regulated health care professionals.”<sup>8</sup> In 1999, the Institute of Medicine (IOM) said that consumers generally believe they are protected within the health care arena because “licensure and accreditation confer, in the eyes of the public, a ‘Good Housekeeping Seal of Approval,’ and suggested greater assessment of the physicians’ performance of skills after initial licensure.”<sup>9</sup> Two years later, the IOM observed that in a profession with “a continually expanded knowledge base,” a mechanism was needed to ensure that practitioners remain up to date with current best practices.<sup>10</sup> It also noted that medical regulation, when properly conceived and executed, “can both protect the public’s interest and support the ability of health care professionals and organizations to innovate and change to meet the needs of their patients.”

**Rationale for Enhanced Medical Regulation**

In the United States and United Kingdom, according to a survey of 18 countries conducted last year, more than 80 percent of the public consider physicians to be trustworthy.<sup>11</sup> To continue to earn such high regard in a climate of greater accountability and regulation, consistent with their own professional obligations to remain competent and up-to-date, physicians need to demonstrate to their patients and peers what most are already doing. The rationale to do so, however, is multifaceted and not limited to well-intentioned policy reports or professional obligations. While unequivocal, comprehensive and robust research in support of a multi-component program for maintenance of licensure is not yet available, simply because no medical regulatory authority

has fully implemented such a plan, there is growing evidence in the medical literature about 1.) the practice of physicians over time, and 2.) the value of enhanced continuing medical education or continued professional development. Both of these categories are addressed by the FSMB's MOL framework.

Several studies over the years have found, for instance, that practicing physicians who perform

**A COMPREHENSIVE PROGRAM FOR MAINTENANCE OF LICENSURE, IF ADOPTED BY ALL STATE MEDICAL AND OSTEOPATHIC BOARDS, COULD LOGICALLY AND OBJECTIVELY DEMONSTRATE WHICH PHYSICIANS ARE ENGAGED IN CLINICAL ACTIVITY AND HOW MUCH.**

a lower volume of clinical or surgical procedures, or who have less experience with specific conditions or diseases, have higher rates of complications compared with their physician colleagues. As one researcher and his colleagues hypothesized in 1987, in the treatment of disease it would appear that practice makes perfect.<sup>12</sup> Kimmel and colleagues in 1995 studied more than 19,000 patients undergoing coronary angioplasty procedures by interventional cardiologists at cardiac catheterization laboratories across the United States and Canada and, after adjusting for case mix, found an inverse association between cardiac catheterization laboratory procedure volume and major complications.<sup>13</sup> An inverse association between the number of coronary artery bypass graft surgeries performed by cardiac surgeons and subsequent mortality rates, after adjustment for clinical risk factors, has also been described.<sup>14, 15 16</sup>

In a 1996 study of 403 adult male patients with the Acquired Immunodeficiency Syndrome (AIDS) who were cared for by 125 primary care physicians, after controlling for the severity of illness and the year of diagnosis, patients cared for by physicians with the most experience had a 31 percent lower risk of

death than patients cared for by physicians with the least experience.<sup>17</sup> Nash and colleagues found a lower mortality rate from acute myocardial infarction among patients of both primary care physicians and cardiologists who had higher patient volumes than those physicians who provided care for this condition less frequently.<sup>18</sup> A study by Tu and colleagues in 2001 found that patients with acute myocardial infarction who are treated by “high-volume admitting physicians” for that condition are comparatively more likely to survive at 30 days and at one year.<sup>19</sup> And Freeman and colleagues found a substantial variation in the clinical outcomes of gastrointestinal endoscopy based on the ongoing case volume of the gastroenterologist.<sup>20</sup>

Choudhry and colleagues conducted a systematic review of the relationship between clinical experience and quality of health care in 2005 and found that physicians who have been in practice longer may be at risk for providing lower quality care and that this subgroup of physicians may benefit from quality improvement interventions.<sup>21</sup> While underperformance among physicians is neither very well studied nor defined, it has been suggested that age-related cognitive decline, impairment due to substance use disorders and other psychiatric



illness may contribute to underperformance, diminishing physicians' insight into their level of performance as well as their ability to benefit from an educational experience.<sup>22</sup>

As for enhanced continuing medical education (CME) and continued professional development (CPD), the Johns Hopkins Evidence-based Practice Center for Healthcare Research and Quality

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conducted a systematic review of the effectiveness of such education and reported in 2009 that multimedia, multiple instruction techniques and multiple exposures to content were associated with improvements in physician knowledge.<sup>23</sup> There is also evidence that such CME/CPD practices are effective in changing physician performance,<sup>24</sup> though more research is needed that focuses on the specific types of media and educational techniques that lead to the greatest improvements in performance. In a Cochrane database review of 81 trials looking at continuing medical education, Forsetlund and colleagues concluded that strategies to increase attendance at educational meetings, using mixed interactive and didactic formats, and focusing on outcomes that are likely to be perceived as serious may increase the effectiveness of educational meetings.<sup>25</sup>

State medical and osteopathic boards have occasionally struggled with a subset of physicians with active licenses who are no longer clinically active, and have looked at how clinical inactivity should be defined, identified, monitored and communicated or shared with the public. In a 2007 telephone survey of 64 state medical and osteopathic boards in the United States, excluding its territories, Freed and colleagues found that only 22 state licensing boards (34%) query physicians regarding clinical activity at both initial licensure and licensure renewal, with the majority of boards permitting physicians to hold or renew an unrestricted active license to practice medicine, although they may not have cared for

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ANY IMPROVEMENTS OR CHANGES IN LICENSURE RENEWAL SHOULD LOGICALLY AND APPROPRIATELY BE LED, AND GUIDED, BY STATE MEDICAL AND OSTEOPATHIC MEDICAL BOARDS. THE FSMB CAN ASSIST BY FACILITATING THE DEVELOPMENT OF POLICIES AND PROCEDURES.

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a patient in years.<sup>26</sup> A comprehensive program for maintenance of licensure, if adopted by all state medical and osteopathic boards, could logically and objectively demonstrate which physicians are engaged in clinical activity and how much—a derivative benefit that would be useful for health care workforce analyses and predictions. A special committee commissioned this year by Freda Bush, M.D., FSMB Board Chair, to look at physician reentry and related issues on behalf of state medical and osteopathic

boards should be helpful in framing the context and offering guidance.

A rationale for a more robust or enhanced program of medical regulation is not only predicated on the need to protect the public and promote quality health care delivery. It has been argued that profligacy in the care of one patient within an increasingly cost-contained health care system or organization could lead to less adequate care for another patient.<sup>27</sup> A program to promote the ongoing clinical competence of actively licensed physicians could support the adoption, or awareness, of best practices in the management of all patients and their illnesses. A less obvious impetus for state medical and osteopathic boards to embrace changes and improvements in medical regulation is the concern that if they don't, others may. Medical regulation outside the bounds of state licensing authority could in turn, as one observer notes, lead to damaging effects to patients and society.<sup>28</sup> As representatives of the people of the state, usually appointed or elected by state officials (e.g., governor), state medical and osteopathic boards are sworn to protect the public and promote quality medical licensure and discipline. Any improvements or changes in licensure renewal should logically and appropriately be led, and guided, by state medical and osteopathic boards. The FSMB can assist by facilitating the development of policies and procedures, encouraging common practices while respecting states' autonomy and collaborating with health care organizations with expertise in physician assessment, public safety and practice performance.

### **Evolution of Maintenance of Licensure**

All actively licensed physicians in the United States and its territories are required to renew their license every one to three years, depending upon the requirements of their state medical or osteopathic board.<sup>29</sup> Most state boards use a variety of information sources to document and verify the competence of physicians seeking licensure renewal: prescribed hours of accredited continuing medical education (CME), information that is usually self-reported but sometimes verified by random audits; hospital privilege reports; disciplinary data banks—such as the Federation of State Medical Boards' (FSMB) Board Action Data Bank or the National Practitioner Data Bank; patient complaints; and medical malpractice reports.

In May of 2003, following discussions centered around the need to improve the capability of state

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medical and osteopathic boards to protect the public and promote quality health care, the FSMB, under its Board Chair, Thomas D. Kirksey, M.D., convened a special committee to make recommendations about the possibility of a system for the periodic assessment of the ongoing clinical competence of actively licensed physicians, what came to be known as “maintenance of licensure” (MOL).<sup>30</sup> Following discussions and review of existing practices, the committee recommended a substantive policy statement that was adopted the following year by the FSMB’s House of Delegates: “State medical boards have a responsi-

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...PHYSICIANS ENROLLED IN THE ABMS’ MAINTENANCE OF CERTIFICATION (MOC) PROGRAM, OR THE AMERICAN OSTEOPATHIC ASSOCIATION BUREAU OF OSTEOPATHIC SPECIALISTS’ OSTEOPATHIC CONTINUOUS CERTIFICATION (OCC) PROGRAM, COULD SUBSTANTIALLY COMPLY WITH A STATE LICENSING BOARD’S EXPECTATIONS FOR MOL.

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bility to the public to ensure the ongoing competence of physicians seeking relicensure.”<sup>31, 32</sup>

Beginning in 2005, the FSMB sought input and commentary from leaders and representatives of major health care organizations and federal and state governmental agencies to consider options and programs by which state medical and osteopathic boards should or could implement maintenance of licensure. During the last seven years, multiple discussions, meetings and conferences have been held, with periodic surveys of state medical and osteopathic boards to continuously gauge their concerns and interests. To perform a comprehensive review and to make final recommendations to the Board of Directors about maintenance of licensure, the FSMB, under then Board Chair, Martin Crane, M.D., convened an Advisory Group on Continued Competence of Licensed Physicians in 2009. The Advisory Group was charged to issue an opinion to the FSMB Board of Directors concerning FSMB’s Maintenance of Licensure initiative and, more specifically, whether the framework proposed in the report of the Special Committee on Maintenance of Licensure was feasible, reasonable, consistent with a series of guiding principles adopted by FSMB’s House of Delegates in May 2008, and suitable for use by state medical and osteopathic

boards in ensuring the continued competence of licensed physicians.

The Maintenance of Licensure framework adopted by the FSMB House of Delegates in 2010 notes that as a condition of license renewal, physicians “should provide evidence of participation in a program of professional development and lifelong learning that is based on the general competencies model: medical knowledge, patient care, interpersonal and communication skills, practice-based learning, professionalism and systems-based practice.” One of the framework’s guiding principles is that “maintenance of licensure should not compromise patient care or create barriers to physician practice.”

Discussion and analysis is now under way with an FSMB-sponsored MOL Implementation Group that is guided by the framework and that receives regular input from an advisory council of chief executives from a range of health care organizations. A draft report from the MOL Implementation Group that outlines specific options for state boards will be reviewed this summer by the FSMB’s Board of Directors, then by state medical and osteopathic boards and then by other stakeholders in health care and in government. It is anticipated that a starter (pilot) plan for MOL may be initiated by interested state medical and osteopathic boards as early as the end of the calendar year.

### Components of Maintenance of Licensure

While the specific details, methodologies and options by which state medical and osteopathic boards could implement a program for Maintenance of Licensure are being formulated at press time, several themes have emerged around the three specific components identified in the MOL framework document adopted by the FSMB’s House of Delegates.

The first component of MOL, *reflective self-assessment*, addresses physicians’ professional obligation to commit to lifelong learning to maintain their skills and acquire updated knowledge affecting their practice. This could involve the use of an assessment tool such as an accredited continuing medical education (CME) pre-test, as one example, to identify needs or opportunities for improvement, followed by a tailored improvement activity based on those outcomes. State licensing boards will likely need to modify or enhance, where appropriate, their existing CME requirements.

While the second component of MOL, *the assessment of knowledge and skills*, does not mandate the

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passage of a secure or proctored examination as part of its second component, it notes that physicians enrolled in the ABMS' Maintenance of Certification (MOC) program, or the American Osteopathic Association Bureau of Osteopathic Specialists' Osteopathic Continuous Certification (OCC) program, could substantially comply with a state licensing board's expectations for MOL. Because more than 30 percent of actively licensed physicians are not specialty board certified,<sup>33</sup> most physicians with time-unlimited ("grandfathered") specialty certificates have chosen not to become recertified<sup>34</sup> and a plurality of physicians with time-limited specialty certificates are not seeking renewal of specialty board certification,<sup>35</sup> state licensing boards will need to consider additional options (e.g., computer-based clinical case simulations, hospital procedural privileging) for physicians to demonstrate ongoing clinical competence. The FSMB's MOL Implementation Group, guided by the adopted framework and its advisory council, is reviewing those options now.

For the third component, *performance in practice*, physicians could use data derived from their own practices supplemented by practice improvement activities already being implemented by specialty societies, hospitals, physician groups and quality improvement organizations. As this component is similar to the fourth part of MOC and the "Practice Performance Assessment" part of OCC, state boards may elect to substantially qualify licensees engaged in such activities. According to Kathleen Sebelius, Secretary of Health and Human Services, 20 percent of doctors and 10 percent of hospitals currently use basic electronic health records.<sup>36</sup> As "meaningful use" regulations to promote electronic health records and health information technology advance,<sup>37</sup> and data-driven changes in physician practice gradually take hold, component three of MOL is also the most likely to evolve over time. Regina Benjamin, M.D., M.B.A., U.S. Surgeon General and Past Chair of the FSMB's Board of Directors, recently wrote of her prior experience with health information technology and how "practicing medicine became easier for the clinicians and better for the patients" following the adoption of electronic health records in her private practice setting.<sup>38</sup>

As the MOL Implementation Group deliberates the specifics of how the states could proceed with MOL adoption, the group's members have agreed that the overall process of implementation by the states

should be evolutionary, not revolutionary, while recognizing the need to be anticipatory.

### **International Perspectives on MOL**

The same year that the FSMB's House of Delegates adopted its statement of responsibility in relation to the ongoing clinical competence of physicians, the Federation of Medical Regulatory Authorities of Canada (FMRAC) adopted its framework for maintenance of licensure, a program called revalidation by some Canadian provincial authorities. The FMRAC announced in 2004 that all licensed physicians in Canada must participate in a recognized revalidation process in which they demonstrate their commitment to continued competent performance in a framework that is fair, relevant, inclusive, transferable and formative. The Revalidation Working Group that studied the issue said, "The demonstration of ongoing competence and performance of physicians is a pillar of professional self-regulation."<sup>39</sup> Several Canadian provinces have mandated that physicians participate in an educational program, such as the Royal College of Physicians and Surgeons' Maintenance of Certification program or the College of Family Physicians' Maintenance of Proficiency program, to maintain licensure.<sup>40</sup> Physicians in these programs report their participation in educational activities annually, with random audits of the documentation by the colleges and/or a peer review process involving office visits by physician colleagues.

In England, where the administration of Henry VIII passed legislation in Parliament aimed at

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regulating and licensing medical practitioners that endured without any amendments for 300 years,<sup>41</sup> the General Medical Council began in 1998 to develop a means by which doctors' practices could be appraised and objectively assessed annually over a five-year period as a mandatory condition for what it also calls revalidation.<sup>42</sup> While formal implementation of such a system has now been delayed by a year under the newly elected government in the United Kingdom, when it gets underway it is expected to include as part of its appraisal of

physicians several elements: colleague and patient feedback, continuous professional development (CPD) records and a clinical audit, all within a quality assurance process overseen by Medical Royal Colleges and Faculties and various health systems regulators. It is expected to be a single process for both general practitioners and specialists, regulated by the General Medical Council and implemented within local hospitals with specialist standards set by the individual Royal Colleges.<sup>43</sup>

Other nations, such as Australia, New Zealand and Ireland, are in various phases of implementation of similar programs for maintenance of licensure. All international medical regulatory authorities will differ in the details of how they implement ongoing clinical competence assessment of physicians, but it will be helpful and appropriate for these nations to share best practices, lessons learned, and research emanating from implementation of such programs, perhaps supported by the International Association of Medical Regulatory Authorities, for which the FSMB serves as Secretariat. While the medical regulatory laws may be different around the world, notions of medical professionalism, quality health care, and protecting the public are substantially aligned.

### Concluding Thoughts

A system by which physicians with active licenses to practice medicine in the United States will be required over time to periodically demonstrate ongoing clinical competence in their area of practice as a requirement for renewal of licensure is going to become reality in the near term.

As Cyril Chantler notes with respect to the growing global movement within the medical regulatory community to establish assessment programs for ongoing clinical competence, “Physicians need trust more than regulation, but it is up to them to introduce systems that are comprehensive and fit for most purposes but not too bureaucratic or burdensome.”<sup>44</sup> ■

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## Canada

### **Canada to Launch New Electronic Application Process for Foreign-Trained-Physician Medical Licenses**

Three key agencies involved in medical regulation in Canada have announced they are launching a new process for foreign-trained physicians who want to apply for a medical license in that country — with the goal of streamlining and simplifying the process electronically.

Human Resources and Skills Development Canada (HRSDC), the Federation of Medical Regulatory Authorities of Canada (FMRAC) and the Medical Council of Canada (MCC) will collaborate on the new process, which will allow physicians to apply for a medical license electronically to multiple loca-

CURRENTLY, PHYSICIANS MUST COMPLETE A SEPARATE APPLICATION FOR EACH PROVINCE OR TERRITORY. ONCE THE NEW PROCESS LAUNCHES, THEY WILL BE ABLE TO APPLY THROUGH A SIMPLIFIED, ELECTRONIC SYSTEM TO MULTIPLE REGULATORY AUTHORITIES.

tions in Canada, and support their application by providing access to credentials stored in a national repository.

“This investment is part of the federal government’s overall action plan to work with the provinces and territories to ensure that licensing bodies put in place better programs to recognize foreign credentials,” said Citizenship, Immigration and Multiculturalism Minister Jason Kenney.

Currently, physicians must complete a separate application for each province or territory. Once the new process launches, they will be able to apply through a simplified, electronic system to multiple regulatory authorities.

“FMRAC and its members have been working diligently to streamline requirements across the coun-

try for physician licensing by developing national standards,” said Dr. Bill Lowe, President of FMRAC. “The new national standards will enable regulators to better facilitate physician mobility.”

The application process will build on the MCC’s Physician Credentials Repository, which gathers, verifies and permanently stores electronic copies of physicians’ credentials.

“Once the application for medical registration launches in 2012, the process to apply for a medical license will become much easier,” said Dr. Trevor Theman, Vice-President of the MCC. “Physicians will only have to submit a pre-populated electronic application and provide access to authenticated credentials.” ■

Source: Medical Council of Canada news release, September 2010

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## United Kingdom

### **‘Revalidation: The Way Ahead’ Report Summarizes Reaction to UK Re-Licensure Plans**

The United Kingdom’s General Medical Council (GMC) has published a summary of input from various stakeholders in Scotland on its proposed transition to a new system of re-licensure of physicians, known as “revalidation.”

The 60-page report, titled “Revalidation: The Way Ahead — Response to Our Revalidation Consultation,” provides extensive analysis of input from physicians, patients, nurses and a range of other health care professionals and health care organizations on how revalidation should be structured and implemented in the UK.

Like many countries globally, the various nations of the UK are working to transform their system of licensure to provide a stronger environment for lifelong learning and maintenance of skills.

The UK’s revalidation efforts are built on principles similar to the effort under way in the United States

*continued from previous page*

### United Kingdom | **'Revalidation: The Way Ahead'**

to establish a Maintenance of Licensure (MOL) system.

According to the GMC, the purpose of revalidation is to “assure patients and the public, employers and other healthcare professionals that licensed doctors

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...REVALIDATION SHOULD ADD VALUE FOR BOTH PATIENTS AND DOCTORS AND MUST BE WORKABLE IN THE PRESSURED AND BUSY ENVIRONMENTS IN WHICH MOST DOCTORS WORK.

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are up to date and are practicing to the appropriate professional standards. Although it is widely understood that the delivery of medical care to patients will always involve an element of risk, revalidation will help doctors, employers and the GMC to provide further assurance to patients and the public that doctors working in the UK are fit to practice.”

When revalidation is introduced, doctors who want to maintain their license will be required to demonstrate their ability to practice to the GMC periodically, by participating in a comprehensive system that evaluates performance. The proposed revalidation cycle calls for physicians to go through the process every five years, but the GMC stresses that it won't be a single “point-in-time assessment.” Rather, skills will be assessed through a “continuing evaluation of a doctor's practice in the place in which the doctor works.”

A key part of the UK's strategy in moving toward revalidation was the creation of a “consultation” with stakeholders on various issues and aspects of the transition to a re-licensure system. Between March and June of 2010, the GMC received nearly 1,000 responses from its stakeholder groups. Feedback was received formally, as well as during a series of public events held across the UK.

More than 70 percent of the responses were from individuals, with the remainder from organizations.

Nearly 80 percent of those who responded were physicians.

In announcing publication of the report, GMC said that its consultation with stakeholders showed considerable support for many of its proposals for a revalidation system, but that “there are still some genuine concerns about the process of revalidation and how it will be introduced.”

“The message we heard consistently was that it must be straightforward and proportionate and must not place excessive burdens on doctors or employers,” said Sir Peter Rubin, GMC Chair. “We are committed to reviewing the proposals in the light of the responses and we are determined that revalidation should add value for both patients and doctors and must be workable in the pressured and busy environments in which most doctors work.”

According to the report, five key themes emerged during the consultation process. These included:

- Ensuring that revalidation is as streamlined, straightforward and proportionate as possible.
- Ensuring the revalidation model is flexible.
- Addressing concerns about the potential costs of revalidation.
- The need for further detail before the plan is implemented.
- The need for further testing and evaluation before the plan is implemented.

In response to the fifth theme — the need for more testing and evaluation — an additional year of testing in England has been announced by the Secretary of State for Health, which GMC said will provide “an opportunity to gather further information about the practicalities, costs and benefits of the process,” and “to widen the scope of current testing to evaluate if the model is feasible and applicable for doctors working across different environments and with varied work patterns.”



Other principles that have been adopted as fundamental to the revalidation include creating a system that:

- Includes within it a strong element of patient participation and evaluation.
- Is seen as primarily supportive, focused on raising standards, not a disciplinary mechanism to deal with the small proportion of doctors who may cause concern.
- Includes remediation and rehabilitation as essential elements of the process for the very few who struggle to revalidate, giving them help whenever possible.
- Is a continuing process, not an event every five years, so that problems can be identified and resolved quickly and effectively.
- Should be introduced incrementally through piloting to ensure that it works well.

According to the report, results of the four-month consultation indicated a preference for rolling the system out in stages throughout the United Kingdom. “We also remain of the view that revalidation should be introduced and rolled out incrementally, and that there should not be a ‘big bang’ approach. Different regions and different organizations will be ready at different times and it

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**‘REVALIDATION SHOULD ONLY BE ROLLED OUT WHEN LOCAL HEALTHCARE ORGANIZATIONS ARE READY AND LOCAL SYSTEMS OF APPRAISAL AND GOVERNANCE ARE IN PLACE AND SUFFICIENTLY ROBUST.’**

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makes no sense to wait for the slowest to be ready before its introduction,” the report states, concluding: “In any event, revalidation will evolve as it is implemented, and over time, in response to ongoing evaluation, quality assurance and a more established evidence base, all of which support a phased introduction.”

The GMC has begun testing how revalidation might work in practice. Pilot projects have begun across the UK, involving “thousands of doctors working in different specialties and sectors,” according to the report. The GMC will use results from these projects to modify or fine tune elements of the revalidation plan.

The GMC approach to implementing revalidation is geared towards ensuring the new system is well-thought-through and tested before pressing for its adoption. “Revalidation should only be rolled out when local healthcare organizations are ready and local systems of appraisal and governance are in place and sufficiently robust,” the report recommends.

The report also touches on the need for better information technology systems in order to effec-

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**THE GMC HAS BEGUN TESTING HOW REVALIDATION MIGHT WORK IN PRACTICE. PILOT PROJECTS HAVE BEGUN ACROSS THE UK, INVOLVING ‘THOUSANDS OF DOCTORS WORKING IN DIFFERENT SPECIALTIES AND SECTORS.’**

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tively implement revalidation — a need that is also being expressed as the United States explores an MOL system: “Because revalidation is concerned with how doctors perform in practice, workplace systems of clinical governance and appraisal need to be sufficiently mature to enable doctors to collect the information they need for their revalidation and for that data to be properly evaluated in the workplace,” the report concludes.

For more information about the UK’s revalidation effort, visit [www.gmc-uk.org](http://www.gmc-uk.org). To download a copy of the report, visit [www.gmc-uk.org/doctors/revalidation/5786.asp](http://www.gmc-uk.org/doctors/revalidation/5786.asp). ■

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Source: GMC website, October 2010

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California

**California's Operation Safe Medicine Unit Cracks Down on Circle Contact Lens Sales**

The Medical Board of California recently launched an aggressive effort to counter the growing incidence of unauthorized sales of circle contact lenses — a new kind of contact lens that has gone mainstream in Asia but is still illegal in California.

The board's Operation Safe Medicine unit, made up of four investigators who investigate allegations of unlicensed practice of medicine, set up several undercover buys from unlicensed individuals who were selling circle contact lenses. Working collaboratively, board investigators and the Los Angeles

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WORKING COLLABORATIVELY, BOARD INVESTIGATORS AND THE LOS ANGELES POLICE DEPARTMENT ARRESTED NINE UNLICENSED INDIVIDUALS SELLING CIRCLE CONTACT LENSES...

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Police Department arrested nine unlicensed individuals selling circle contact lenses and the cases were referred to the Los Angeles City Attorney's Office for prosecution.

Circle contact lenses are usually colored and make the eyes seem larger, covering the iris and part of the white portion of the eyes. Though the lenses are popular in other countries, health and safety concerns have restricted their use in the United States. Poorly fitted lenses can scratch the cornea, cause infections and lead to serious problems, including loss of vision and loss of an eye.

Despite being prohibited by law in California, circle contact lenses are easily available on the Internet and from some public vendors. California's Business and Professions Code stipulates that contact lenses may be sold only upon receipt of a written prescription or a copy of a written prescription and in

quantities consistent with the prescription's established expiration date and the standard packing of the manufacturer or vendor.

California's Operation Safe Medicine unit set up several undercover buys from Southern California vendors — including some who were selling the lenses outdoors. Among the charges the vendors face are failure to obtain a patient history, failure to perform an examination, and illegally obtaining and reselling contact lenses without a prescription. ■

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Source: State Medical Board of California website, October 2010

**State Medical Board of California Annual Report Notes Improvements in Results**

The State Medical Board of California's recently published Annual Report for 2009-10 indicates progress on a number of statewide initiatives, as well as improvements in key measurements used to assess results in state physician investigations.

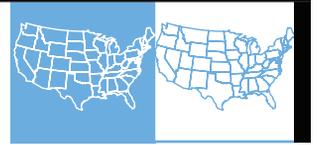
Notably, the California board's Enforcement Program reported that it reduced the average time to complete investigations and increased the number of cases referred to the Office of the Attorney General for disciplinary action and public letters of reprimand in 2009-10, according to the report.

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THE... ENFORCEMENT PROGRAM REDUCED THE AVERAGE TIME TO COMPLETE INVESTIGATIONS, FROM THE RECEIPT OF A COMPLAINT THROUGH THE ENTIRE DISCIPLINARY PROCESS, BY 21 DAYS.

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The board also noted in the report its progress on a new system, implemented late last year, which allows licensing applicants to look up the status of their application online; a licensing outreach program aimed at hospitals and physician recruiters; and its new program that requires California physicians to notify their patients that they are licensed and regulated by the board.



The board's Enforcement Program reduced the average time to complete investigations, from the receipt of a complaint through the entire disciplinary process, by 21 days. As a result of its focus on enhanced efficiency, the program referred 119 more cases to the Office of the Attorney General in 2009-10 than in the previous year.

The program also reported that administration outcomes resulting in the surrender of a license more than doubled, suggesting an improvement in the quality of cases being referred for prosecution.

According to the report, the Enforcement Program's issuance of public letters of reprimand increased by 43 percent during 2009-10. The program attributed much of this increase to the passage of AB1070—California legislation that allows an administrative law judge to recommend that a licensee be issued a public reprimand, including additional requirements for education and training.

The Enforcement Program opened 1,312 cases in 2009-10, compared with 1,123 cases in 2008-09. It closed 1,290 cases in 2009-10, compared with 1,100 in 2008-09. The program reported that consumer inquiries were up significantly, from 15,699 in 2008-09 to 20,447 in 2009-10.

### Administrative Outcomes by Case Type in California

Case Type	Total Actions by Case Type
Gross Negligence/Incompetence	167
Inappropriate Prescribing	24
Unlicensed Activity	2
Sexual Misconduct	23
Mental/Physical Illness	18
Self-Abuse of Drugs/Alcohol	30
Fraud	16
Conviction of a Crime	19
Unprofessional Conduct	45
Miscellaneous Violations	5
<b>TOTAL</b>	<b>349</b>

Administrative outcomes by case type were highlighted in the Annual Report, with the majority of cases involving gross negligence or incompetence, followed by unprofessional conduct, drug and alcohol abuse and inappropriate prescribing (see table).

The report notes that the board's new online application-status system is fully operational. Launched

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### CALIFORNIA EXPANDED ITS LICENSING OUTREACH PROGRAM, ACCORDING TO THE REPORT, REACHING OUT TO MORE TEACHING HOSPITALS AND BEGINNING AN EFFORT TO CONNECT WITH PHYSICIAN RECRUITERS.

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in December 2009, the new system allows licensing applicants to view documents required for licensure at a secure website. An applicant-information screen tells the applicant which documents have been received by the board and indicates those that are missing.

The new system, which the board says was implemented to "streamline and expedite the licensing process," also informs applicants of any documents that have been found to be deficient as well as those that have been approved.

During the fiscal year, California expanded its licensing outreach program, according to the report, reaching out to more teaching hospitals and beginning an effort to connect with physician recruiters. The new outreach initiative includes direct contact from board representatives, who explain the licensing process and how applications are reviewed, and offer to assist with any questions or problems system-users encounter.

According to the report, this "helps applicants identify potential problems they may face and assists the board's staff by promoting the receipt of more properly prepared applications, again expediting the application process."

Highlighted in the report is a summary of a new provision in the California Code of Regulations, imple-

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## STATE MEMBER BOARD BRIEFS

mented in late June of this year, which requires all California-licensed physicians to notify their patients that they are licensed and regulated by the State Medical Board of California.

To fulfill this requirement, the state's licensed physicians must display the board's toll-free phone number and website address. Physicians must display a sign with this information "prominently" or give the information in writing to each of their patients. According to the report, the new requirement "serves the public by informing consumers where to go for information or to complain about a California medical doctor."

The report also provides statistics on California's total pool of licensed physicians, which now stands at 122,451. Of these, 98,816 are based in California and 23,636 are out of state but licensed in California (excluded are those in an inactive, retired, or disabled license status).

The state's heaviest concentration of licensed physicians is in Los Angeles County, with 27,255; followed by San Diego County, 9,365; Orange County, 9,177; Santa Clara County, 6,967; San Francisco County, 5,858; Alameda County, 4,425; and Sacramento County, 4,264.

During the fiscal year, the state's Licensing Program received 5,964 new physicians' and surgeons' applications and issued 5,110 licenses. This compares with 6,169 applications received in 2008-2009 and 4,688 licenses issued.

In addition to the licensing of physicians, the Medical Board of California's Licensing Program licenses non-nurse midwives, research psychoanalysts, spectacle and contact lens dispensers and registered dispensing optician businesses. It also approves accreditation agencies that accredit outpatient surgical centers in which general anesthesia is being used. ■

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Source: State Medical Board of California 2009-10 Annual Report

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## Florida

### **Prescription Drug Monitoring Program Awarded Federal Grant**

The Florida Department of Health (DOH) was awarded a \$400,000 enhancement grant—the maximum amount possible—from the Harold Rogers Prescription Drug Monitoring Program for an electronic system to monitor the dispensing of controlled substances in Florida. When Florida's Prescription Drug Monitoring Program (PDMP) is in place, it will be a repository of data about every

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WHEN FLORIDA'S PRESCRIPTION DRUG MONITORING PROGRAM (PDMP) IS IN PLACE, IT WILL BE A REPOSITORY OF DATA ABOUT EVERY DISPENSING TRANSACTION OF A SCHEDULE II, III, OR IV CONTROLLED SUBSTANCE...

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dispensing transaction of a Schedule II, III, or IV controlled substance between a physician, dentist, or pharmacist, and his or her patient.

After years in development, legislation authorizing the PDMP was passed in 2009 and is now law (s. 893.055, Florida Statutes). The law does not allow for any state funding of the program; however, the recently-awarded enhancement grant and the 2009 Harold Rogers Implementation Grant, also in the amount of \$400,000, will be used to administer the program.

The primary purpose of the Harold Rogers Prescription Drug Monitoring Program is to enhance the capacity of regulatory and law enforcement agencies and public health officials to collect and analyze controlled substance prescription data and other schedule-listed chemical products through a centralized database administered by an authorized state agency. The program was created by



the Fiscal Year 2002 U.S. Department of Justice Appropriations Act (Public Law 107-77) and has received funding under each subsequent year's Appropriations Act. For more information, visit [www.doh.state.fl.us/mqa/medical/](http://www.doh.state.fl.us/mqa/medical/). ■

Source: MCQ Today, Florida Department of Health, October 2010

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North Carolina

### **New State Board Committee on 'Practice Drift' Begins Its Work**

A new North Carolina Medical Board committee on "practice drift" has been established to help produce a position statement on an increasing trend among North Carolina medical practitioners: the outflow of physicians from areas in which they were

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THE BOARD RECENTLY REPORTED A SMALL BUT INCREASING NUMBER OF PHYSICIANS 'DRIFTING' OUTSIDE THEIR FORMAL AREAS OF TRAINING.

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trained into new areas of practice for which they may not have received adequate formal education or training.

The board recently reported a small but increasing number of physicians 'drifting' outside their formal areas of training.

In a news announcement, the board said it "recognizes that the evolution of physician practice is not necessarily negative. However, the board has a duty to protect the public by assuring that physicians treating North Carolinians are competent in whatever fields of medicine or surgery they practice."

The board's new committee, named the Special Task Force on Practice Drift, began its work in October, inviting a variety of stakeholders to participate in an initial meeting. Invitees included representa-

tives from professional liability insurance companies, physician professional groups representing both specialists and general medical practitioners and others. Twenty one participants attended the first meeting.

Areas into which both primary care and specialty physicians are "drifting" in North Carolina include cosmetic procedures, mental health, and pain management, according to the board.

The Special Task Force concluded its meeting with a consensus vote that a Position Statement be drafted to state that the board expects licensees to ensure that they are competent in the new area in which they are practicing. The Special Task Force aims to have a draft statement prepared in time for the board's regular meeting in January 2011. ■

Source: North Carolina Medical Board website, October 2010

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Iowa

### **Board Ad Hoc Committee to Study a Range of Telemedicine Issues**

The Iowa Board of Medicine has appointed a committee that will help it determine how to ensure that its policies on a physician's practice of medicine

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ACCORDING TO THE BOARD, THE COMMITTEE'S REVIEW 'WILL ENCOMPASS A BROAD RANGE OF MEDICAL APPLICATIONS.'

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over the Internet and by means other than a face-to-face visit with a patient remain "relevant to the continually expanding use of telemedicine."

Iowa Board of Medicine Chair Siroos Shirazi, M.D., appointed an ad hoc committee in August that will study the board's 1996 policy statement to determine what changes may be needed. According to the board, the committee's review "will encompass a broad range of medical applications."

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## STATE MEMBER BOARD BRIEFS

The committee will begin a review of the policy statement and the general topic of telemedicine this fall, but may not complete its work until a parallel nationwide study is completed in 2011, according to the board.

Members of the ad hoc committee include Iowa Board of Medicine members Amber Mian; Colleen Stockdale, M.D.; Joyce Vista Wayne, M.D.; former board member Carole Frier, D.O.; and board staff. The ad hoc committee will likely invite participation by others who have expertise in telemedicine issues.

The board's policy statement is based in part on a 1996 report by the Federation of State Medical Boards. Shirazi said the board's policy statement is not a legally binding opinion, but is only intended to provide guidance to the public. The board may make formal policy only through administrative rules, declaratory orders or contested case decisions. ■

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Source: Iowa Board of Medicine news release, August 2010

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### Ohio

#### **Physician Licensure Renewal Form Redesigned to Give More Accurate Picture of Physician Workforce**

The State Medical Board of Ohio has launched a redesign of its online physician renewal application form that will now include questions related to physician demographics.

The new form includes a series of mandatory demographic questions, which the board said in a news release are intended to provide better data to help state officials as they make decisions related to the physician workforce. In announcing the redesign, the board said the new demographic questions will enable it to gain "a more accurate illustration of the

Ohio physician workforce than has ever before been available."

The state's demographic questions include:

- The number of hours per week a physician spends in direct patient care and other activities, and the clinical setting of such activities.
- The county and zip code of the location(s) where the physician provides the most patient care.
- Whether the physician is a solo practitioner, part of a group practice, or employed by a clinical facility or hospital.
- Whether languages other than spoken English are available at the primary practice location.
- Board certification status.

All of the demographic questions on the online renewal form can be answered by choosing the appropriate response from a drop-down box. Answers must be provided to the questions in order

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IN ANNOUNCING THE REDESIGN, THE BOARD SAID THE NEW DEMOGRAPHIC QUESTIONS WILL ENABLE IT TO GAIN 'A MORE ACCURATE ILLUSTRATION OF THE OHIO PHYSICIAN WORKFORCE...'

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to continue the renewal process. The average time to complete the online renewal remains 15 minutes or less, according to the board. License renewal notices are sent by the Ohio board six months before the license expiration date.

For more information about the new form, visit [www.med.ohio.gov](http://www.med.ohio.gov). ■

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Source: State Medical Board of Ohio news release, October 2010



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Texas

## **New Program Assists Health Professionals with Impairment Issues**

The Texas Medical Board has established a new, statewide program that aims to protect the public by encouraging health professionals to seek early assistance with drug or alcohol-related problems or mental or physical conditions that present a poten-

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TXPHP ACCEPTS SELF-REFERRALS AS WELL AS REFERRALS FROM THE TEXAS MEDICAL BOARD, CONCERNED COLLEAGUES, HOSPITALS AND OTHERS.

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tially dangerous limitation or inability to practice medicine with reasonable skill and safety.

The Texas Physician Health Program, or TXPHP, is a confidential, non-disciplinary program for physicians, physician assistants, acupuncturists and surgical assistants licensed by the Texas Medical Board or who have applied for licensure.

TXPHP, launched earlier this year, was created by Texas Senate Bill 292. It is modeled on other states' programs and was a joint effort of the Texas Medical Association, the Texas Osteopathic Medical Association, and the Texas Medical Board. TXPHP is self-funded through user fees, with the cost for participation in the program \$1,200 per year.

TXPHP accepts self-referrals as well as referrals from the Texas Medical Board, concerned colleagues, hospitals and others. The program is overseen by experts in mental health and substance abuse issues.

TXPHP recommends treatment for physicians when clinically indicated, and monitors their ongoing recovery. A monitoring program may include random drug screens, written reports from counselors or therapists, self reports provided by the physician in recovery, and written verification of attendance at self-help or support group meetings.

TXPHP is administratively affiliated with the Texas Medical Board, but overseen by an 11-member governing board.

To learn more about TXPHP, visit [www.tmb.state.tx.us](http://www.tmb.state.tx.us). ■

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Source: Texas Medical Board news release, September 2010



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## Help us commemorate FSMB's Centennial in 2012!

Preparations are under way to celebrate the Federation of State Medical Boards' Centennial year in 2012. The year-long celebration of the FSMB and all state medical boards will include:

- A written history of the FSMB
- Historical highlights of each state medical board
- Special events at the 2012 FSMB Annual Meeting in Fort Worth, Texas
- Website content commemorating medical regulation over the last century

The FSMB welcomes the submission of any historical materials that could help document and celebrate the accomplishments of the FSMB and the important work of state medical boards. Materials could include photographs, copies of key archival documents, articles, personal memoirs and previously written medical board histories.

**Your contributions are greatly appreciated.**

Historical materials may be sent to:  
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For more information about the FSMB Centennial Project, please contact:  
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CRITICAL THINKING ON ISSUES  
OF MEDICAL LICENSURE AND DISCIPLINE

VOLUME 97  
NUMBER 1  
2011

## Physician Reentry into Clinical Practice

An Examination of  
Regulatory Challenges

### ALSO IN THIS ISSUE

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**Characteristics  
and Clinical Abilities  
of Reentering  
Physicians**

.....

**News from State  
Medical and  
Osteopathic Boards**

.....

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BOARDS**





VOLUME 97, NUMBER 1, 2011

**2** Publisher's Information

.....

**3** Quoted | Note from the Editor

**4** News & Notes



**5** Message from the Chair

.....

**8** **A Summary of the Coalition for Physician Enhancement's Spring 2011 Meeting: "Exploring Physician Reentry: Policies and Processes"**

Robert S. Steele, M.D., FAAFP

.....

**10** **Physician Reentry into Clinical Practice: Regulatory Challenges**

Gretchen P. Kenagy, Ph.D.

Barbara S. Schneidman, M.D., M.P.H.

Barbara Barzansky, Ph.D., M.P.H.E.

Claudette E. Dalton, M.D.

Carl A. Sirio, M.D.

Susan E. Skochelak, M.D., M.P.H.

.....

**16** **Physicians Reentering Clinical Practice: Characteristics and Clinical Abilities**

Elizabeth S. Grace, M.D.

Elizabeth J. Korinek, M.P.H.

Lindsay B. Weitzel, Ph.D.

Dennis K. Wentz, M.D.

**24** International Briefs



**26** State Member Board Briefs



**31** Information for Authors



WHAT KINDS OF  
POLICIES HAVE STATE  
MEDICAL BOARDS  
DEVELOPED TO ADDRESS  
PHYSICIAN REENTRY?

**Published Continuously Since 1915 | Volume 97, Number 1, 2011**

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## **Skill and confidence are an unconquered army.**

— George Herbert  
(English poet and clergyman, 1593–1633)

**PROFESSIONAL SKILL** doesn't develop overnight; in most cases, in fact, true mastery is the result of years of hard work and sacrifice. Renowned composer and producer Quincy Jones has said it takes at least 10,000 hours of practice to master an instrument, and one can only imagine how many free throws Michael Jordan shot before he even set foot on an NBA court. Medicine is no different. Add up the typical number of hours that go into just a single year of residency and you'll get a sense of what's required to become a skillful physician. But skill is only part of the equation: As George Herbert noted almost 400 years ago, it's the addition of confidence that creates a true pinnacle of excellence—and that requires even more time and even more work. Years of intense focus can bring a physician to this magical combination of skill and confidence, and patients surely benefit. But what happens if that same physician steps away from medicine for a few years, then chooses to return to active practice? Can we expect the medical equivalent of missed free throws or sour notes when he or she returns? We know how much time goes into creating medical skills, but how long does it take for them to fade? Questions like these are at the heart of the work that more and more policy makers and researchers are engaged in as they seek balanced guidelines for physician reentry—a topic of critical importance as more and more physicians opt to come and go from the active workforce. We have visited physician reentry in these pages in the past and, thanks to growing interest, are devoting the lion's share of this issue to it: **On page 10 and 16 we offer two enlightening research studies and on page 8 we bring you highlights from an important conference on physician reentry held earlier this year.** We hope you find this information useful.

**Susan R. Johnson, M.D.**

*Editor in Chief*



## FSMB Releases 2011 Annual Report

The FSMB has released its 2011 Annual Report, titled “New Directions: Shaping the Future of Medical Regulation,” offering a comprehensive look at the activities of the Federation of State Medical Boards and state medical and osteopathic boards during the last year.

Among the highlights of the report are summaries of FSMB’s advocacy activities, including the opening of a new office in Washington, D.C., and the hosting of a major national symposium on the future of telemedicine.

The report includes details of FSMB’s licensure, credentialing and assessment activities, including recent major expansion of its Federation Credentials Verification Service (FCVS) with new features that make the credentials verification process faster and more efficient. According to the report, by the end of 2010, 63 of the 69 state boards that license physicians had become users of FCVS; 14 require it for licensure processing.

The report also includes highlights of FSMB’s initiatives aimed at facilitating medical licensure portability and its work with the National Board of Medical Examiners in enhancing and improving the United States Medical Licensing Exam (USMLE) and Special Purpose Examination (SPEX).

Various educational initiatives are highlighted, along with an update on FSMB’s Maintenance of Licensure (MOL) project and a report on the FSMB Foundation’s new public-member initiative. A special section provides short summaries of innovative programs in regulation and licensing from state boards in Alabama, Arizona, Delaware, Iowa, Indiana, North Carolina, and Washington, D.C.

According to the report, FSMB responded to more than 300,000 inquiries regarding board action and licensure data on U.S. physicians in 2010, and it responded to thousands of additional public requests for information from its DoCInfo database.

To read a copy of the report, visit [www.fsmb.org](http://www.fsmb.org). A link to the report is available on the homepage. ■

## New Members Join FSMB Board of Directors

Delegates at the Federation of State Medical Boards’ 99th Annual Meeting, held April 28–30 in Seattle, Wash., elected new board members, officers and committee members.

The following individuals were elected to the FSMB Board of Directors:

- **Janelle A. Rhyne, M.D.**, of the North Carolina Medical Board, assumed the position of Chair of the Board of Directors.
- **Lance A. Talmage, M.D.**, of the Medical Board of Ohio, was designated Chair-elect.
- **Hedy L. Chang, M.S.**, a public member of the Medical Board of California, was re-elected to a three-year term as a director.
- **Arthur S. Hengerer, M.D.**, of the New York State Board of Professional Medical Conduct, was elected to a three-year term as a director.
- **J. Daniel Gifford, M.D.**, of the Alabama State Board of Medical Examiners, was elected to a three-year term as a director.
- **Tammy L. H. McGee, M.B.A.**, a public member of the Minnesota Board of Medical Practice, was elected to a one-year term as a director.
- **Richard A. Whitehouse, Esq.**, executive director of the Medical Board of Ohio, became the board’s new associate member for a two-year term.

The following individuals were elected to two-year terms on the FSMB Nominating Committee:

- **S. Paul Edwards, J.D.**, Nevada State Board of Osteopathic Medicine.
- **Geraldine T. O’Shea, D.O.**, Osteopathic Medical Board of California.
- **Louis E. Rosenthal, M.D.**, New Hampshire Board of Medicine. ■

### Focusing on the Fundamentals: An Agenda for a Landmark Year

Janelle A. Rhyne, M.D., MACP  
Chair, Board of Directors  
Federation of State Medical Boards

**IN BRIEF** Dr. Rhyne outlines the key goals and action steps she will prioritize during her year as chair of FSMB's Board of Directors, during which FSMB will begin its Centennial celebration.

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In medicine, as in many human endeavors, excellence comes after one masters the fundamentals. That's why our years in medical school years are so important—they establish a solid foundation for all that is to come later as physicians specialize and evolve professionally.

As I begin my year as chair of the FSMB Board of Directors, I find myself thinking of fundamentals in the context of medical regulation—and what we as regulatory professionals can gain from periodically focusing our attention on our most basic foundational principles.

Our mandate is quite simple, if boiled down to its essentials: protecting the public's safety...ensuring the integrity of medical practice...verifying the accuracy of information. No matter how complex the day-to-day operations of state medical and osteopathic boards become, they are really driven by these simple goals.

They represent *our* fundamentals.

My year as chair coincides with FSMB's Centennial celebration, making this a perfect time for all of us in the regulatory community to reflect on these fundamentals—and ensure we are remaining true to them.

I believe our state-based, autonomous system of licensing and regulation has provided us with an effective system to achieve our fundamental goals—and I will spend my year as chair doing all I can to maintain and promote it.

I will also put a strong emphasis during the coming year on strengthening FSMB outreach to state medical and osteopathic boards.

The Federation has an important role, I believe, in identifying and developing more efficient and effective ways for our member boards to fulfill their missions, and helping them share information with each other about their projects and initiatives.

You might say that the FSMB serves as a clearing-house for ideas about the work of state boards. We help facilitate dissemination of ideas and new ways of connecting among the boards—from the diverse informational sessions at our Annual Meeting to our monthly roundtable telephone calls, which state board staff members are invited to participate in.

The FSMB bolsters its connecting role by assigning each board an FSMB staff member who serves as that board's liaison for any questions, concerns or

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OUR MANDATE IS QUITE SIMPLE, IF BOILED DOWN TO ITS ESSENTIALS: PROTECTING THE PUBLIC'S SAFETY...ENSURING THE INTEGRITY OF MEDICAL PRACTICE...VERIFYING THE ACCURACY OF INFORMATION.

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ideas that may arise. That person has the responsibility to ensure that his or her contact at that board gets reliable, consistent and timely information.

In the upcoming year, liaison personnel will meet periodically to share information so that they may have a broad view of current events and ideas outside the scope of their assigned boards.

This year, I intend to do my utmost to ensure that this process of sharing and communication—among the boards themselves and between the boards and the FSMB—remains as active and robust as ever. In the belief that promoting our connection with one another gives us the capacity to continuously improve the work we do, I will give this high priority.

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I will pay particular attention to best practices — the kinds of innovations some *JMR* readers may have seen highlighted in this year’s FSMB annual report, titled “New Directions: Shaping the Future of Medical Regulation” (available at our website, [www.fsmb.org](http://www.fsmb.org)). Along with the board and staff liaison — and with our colleagues in Administrators in Medicine (AIM) — we will endeavor to identify best practices and publicly recognize them at next year’s FSMB Annual Meeting.

Further, we have begun working on new ways to use the FSMB’s web capabilities to provide state boards with useful comparative information and other resources.

Another important goal during my year as chair will be to move forward a discussion of our needs in the regulatory community for a better system of metrics and measurement. While state boards exist to protect and serve the public and, necessarily, undergo public scrutiny, we lack a standard set of metrics for evaluating how well we fulfill our missions.

I believe this is a glaring deficiency in an otherwise well-balanced system. It presents challenges that medical regulators wrestle with every year.

Even though physicians undergo myriad reporting regimens — from state boards, hospitals, large practices, health care purchasers, and consumer watchdogs, to name a few — there are real questions about the measurement data’s fairness to physicians and usefulness to the public.

An example is the Composite Action Index (CAI), a weighted average of disciplinary actions taken against physicians practicing in a state, as well

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WHILE STATE BOARDS EXIST TO PROTECT AND SERVE THE PUBLIC AND, NECESSARILY, UNDERGO PUBLIC SCRUTINY, WE LACK A STANDARD SET OF METRICS FOR EVALUATING HOW WELL WE FULFILL OUR MISSIONS.

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as all physicians licensed by that state, that FSMB has computed since 1993. Actions affecting physicians’ licenses, such as revocations and suspensions, are weighted more heavily in a state’s CAI, and the validity of the CAI is limited in states that have total in-state physician licensee populations of less than 1,000.

The CAI is just one of many components in our current reporting system that should be evaluated as a part of an overall effort to move toward a better system of measurement and metrics. I have begun the appointment of a workgroup to explore how we can create a fair, accurate and useful system of measurement and comparison for regulators and the public.

Beyond these priorities there are other important agenda items for FSMB that will be a part of my focus over 2011–2012:

**Physician reentry:** As you will see by the articles in this issue of the *JMR*, physician reentry continues to grow as a topic of interest in the United States. The passage of the Patient Protection and Affordable Care Act, which is expected to pave the way for tens of millions of new participants in the insurance system, and projected physician-workforce shortages are just two of the trends which point to the likelihood that physicians will be returning to the workforce in greater numbers in years to come.

The pressure will be on state regulators as they seek ways to ensure that returning physicians are adequately prepared to provide care. During my term as chair, FSMB will continue its recent work in reexamining its physician reentry policies and facilitating national discussion of this topic.

**Telemedicine:** Some readers of *JMR* may have attended FSMB’s symposium on the future of telemedicine, titled “Balancing Access, Safety and Quality in a New Era of Telemedicine,” held in early March in Washington, D.C. I was a part of the symposium and participated in large-group and small-group sessions along with nearly 100 other leaders from diverse sectors who brainstormed action steps to help regulators deal with challenging issues related to telemedicine as it continues to evolve. A summary of the symposium, including highlights of these action steps, will be distributed by FSMB this summer.

FSMB has been active as a policy leader in telemedicine since the 1990s and will be re-examining its most recent policy statements as a follow-up to the symposium. During my year as chair, telemedicine will remain high on my priority list.

**Maintenance of Licensure (MOL):** Although the MOL framework has already been established, the FSMB plans to disseminate additional information with respect to model statutory language, licensee

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and stakeholder communication, and pilot projects for its implementation in coming months. We will continue to communicate closely with other organizations as we develop the framework. We will also establish a workgroup to define the pathway that clinically inactive physicians with an unrestricted license may follow to complete MOL requirements.

Many U.S. physicians may not be aware that a wide range of countries globally have begun a similar path toward MOL systems—including the United Kingdom, which is well on the way to

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**WE BELIEVE AN IMPORTANT NEXT STEP IN THE PROCESS OF INTRODUCING MOL IS RAISING AWARENESS AND UNDERSTANDING OF IT AMONG OUR NATIONAL PHYSICIAN WORKFORCE.**

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its version of the concept, known as “revalidation.” We believe an important next step in the process of introducing MOL is raising awareness and understanding of it among our national physician workforce. Over the coming year we will work closely with members of the Federation who have expressed interest in MOL pilot projects to help them as they begin to communicate with physicians in their states.

**Ethics and Professionalism:** If in the coming year we are to focus on the fundamentals of medical regulation, we surely must revisit ethics and professionalism—a topic that pops up periodically in the media. As the voice of the regulatory community, FSMB is in a position to have impact in promoting ethical and professional behavior. I am appointing a new Special Committee on Ethics and Professionalism, which will be tasked with ensuring that our policies are relevant and our leadership robust in this key area of concern.

**Advocacy:** FSMB is an active advocate for the regulatory community, with both national and state legislators, on a broad variety of issues, from license portability to opioid prescribing. Our new Washington, D.C., Advocacy Office has increased our impact, as has our new grassroots advocacy network. I will be working closely with our advocacy staff in the coming year to continue this momentum. As a part of our work, we will thoroughly examine health care reform issues to determine our role in this area and to ensure the relevance of our

mission in the face of much uncertainty in an environment of change.

**FSMB Centennial:** As noted, the FSMB Centennial, which formally begins next January, will make my year as chair extra-special. Given the strong foundation of our 99-year history, we look confidently forward to our Centennial celebration during the 2012 Annual Meeting in Fort Worth and later at an October Washington, D.C. symposium, which is in the planning stages.

In all of these endeavors I will strive to bring the focus of our FSMB leadership team—and the Federation in general—back to the notion of fundamentals, asking ourselves constantly if we are getting the basics right in all that we do.

As we reflect back on the rich history of the Federation in the coming year, and at the same time look forward to our future, I believe our state boards are well positioned to provide the American people with the assurance of safety and quality in their medical care that they expect and deserve.

I look forward to being a part of that effort as FSMB chair over the year to come. ■

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# A Summary of the Coalition for Physician Enhancement’s Spring 2011 Meeting: “Exploring Physician Reentry: Policies and Processes”

Robert S. Steele, M.D., FAAFP

Executive Vice President, Coalition for Physician Enhancement (CPE)  
Medical Co-Director, Physician Assessment Services, Office of Continuing Professional Development, University of Wisconsin School of Medicine and Public Health

**IN BRIEF** The author summarizes the proceedings of a major conference on physician reentry.

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The topic of physician reentry is receiving increasing attention in the health care community — particularly in terms of its impact on anticipated workforce shortages. Trend data and analysis suggest that reentering physicians could help the United States address the coming shortfall of practicing physicians.

Among the concerns and challenges that come up in physician-reentry discussions is the topic of patient safety. As the regulatory community goes about its task of public protection, it will need to find reentry pathways that address patient safety while being accessible, affordable and acceptable for physicians as they seek to transition competently back to the workforce.

A recent program, hosted by the Coalition for Physician Enhancement (CPE), focused on these and other topics. Highlights from the program are offered here as a resource for regulators interested in current trends as they review their own state policies on physician reentry.

## Background

“Exploring Physician Reentry: Policies and Processes,” presented by CPE and hosted by the University of Wisconsin Physician Assessment Services in Madison, Wisc., was held June 2–3, 2011. Forty-three people from the United States and Canada attended the meeting, including CPE members who are involved with the assessment and education of post-licensure physicians, medical board members, and representatives from the American Medical Association (AMA), the Federation of State Medical Boards (FSMB), the American Board of Medical Specialties (ABMS) and the American Academy of Pediatrics (AAP).

CPE is an incorporated consortium of professionals with expertise in quality assurance, medical education and the assessment, licensing and accreditation of referred physicians seeking higher levels of performance in patient care. Most of the members of CPE, which includes individuals and organizations, are involved in the assessment and remediation of physicians seeking reentry to practice. Many CPE members and organizations have significant experience with these physicians. More information about CPE can be found at [www.physicianenhancement.org](http://www.physicianenhancement.org).

Reentry has workforce and patient safety implications, and it is defined as “returning, after an extended absence, to the professional activity/clinical practice for which one has been trained, certified or licensed.”<sup>1</sup> The definition has evolved to also state that no practice or performance

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LIFELONG LEARNING OF PHYSICIANS SHOULD BE FOSTERED AND PROMOTED, AND THERE SHOULD BE DECREASED EMPHASIS ON THE STIGMA OF REMEDIAL EDUCATION.

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problems existed before that absence. Very little data on the number of potential reentry physicians exist; however a survey by Jewett et al found that of physicians aged 65 and over, 19.4 percent (226) of the final sample group (1,162) had reentered practice.<sup>2</sup>

## Meeting Summary

This meeting began with four plenary presentations on the current national status of reentry, the ongoing challenges and opportunities facing this initiative, the definitions associated with reentry and addressing their potential stigma, and a

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presentation and panel on designing assessments for reentry physicians.

Four workshops followed, including “How to assess reentry physicians,” “The unique characteristics of reentry physicians and their implications on performance and program design,” “Implications and considerations of reentry from the standpoint of medical licensing boards,” and “Examining the anchors and important curricular milestones of

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**PHYSICIANS OUT OF PRACTICE FOR PROLONGED PERIODS OF TIME MAY HAVE MORE EDUCATIONAL NEEDS AND MAY MERIT A MORE IN-DEPTH ASSESSMENT AND A LONGER CLINICAL EDUCATION EXPERIENCE.**

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the reentry process.” The final part of the meeting featured the CPE research forum, which included presentations of papers and abstracts that relate to physician reentry and the remedial education of physicians.

**Key points from the meeting**

- Availability of part-time work and flexibility are important reasons that physicians return to practice.
- Reentry should be considered a common career trajectory, not an exception to the rule.
- Enhancement of communication between state medical boards, physicians and those involved with the education of physicians decreases barriers to reentry.
- Current licensing board processes may create barriers to physician reentry in some jurisdictions.
- Lifelong learning of physicians should be fostered and promoted, and there should be decreased emphasis on the stigma of remedial education.
- A thoughtful and comprehensive physician assessment is vital before physicians return to practice; it should be individualized, based on their unique circumstances, and should be done independently from the medical board.
- Physicians out of practice for prolonged periods of time may have more educational needs and may merit a more in-depth assessment and a longer clinical education experience.
- Data presented at this meeting suggests that cognitive screening should be considered for

all reentry physicians due to a positive screen rate of around 20 percent found in one small study of reentry physicians. More research in the area is needed.

- A clearly defined and enhanced vetting process may be needed for clinical mentors for reentry physicians.
- CPE and other stakeholders could collaborate on tools, guidelines and other educational resources to enhance the performance of reentry mentors.

**Next Steps**

This meeting brought together key stakeholders in physician reentry and resulted in significant sharing of ideas, data and research. A number of collaborations were suggested or planned by attendees. The verbal and written feedback about the program has been strongly positive. With the help of other stakeholders, CPE will remain active in supporting providers of reentry programs, and will continue to help advance reentry initiatives, including the development of best practices in the assessment, clinical education and curricular design for reentry. We invite ongoing collaboration with other stakeholders. ■

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# 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

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## 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."<sup>1</sup> 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.<sup>1</sup> 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

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

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 policies 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.<sup>3</sup> Physicians may expect to take time away from practice at some point during

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## 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.

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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.<sup>4-7</sup>

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.<sup>7</sup>

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.<sup>5,8</sup> 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."<sup>9</sup> 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."<sup>9</sup> 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.<sup>10</sup>

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.

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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).<sup>11</sup> 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.”<sup>12</sup>

The three components of MOL are: (1) reflective self assessment; (2) assessment of knowledge and skills; and (3) performance in practice.<sup>11–12</sup> Of particular relevance to physician reentry is component 3, performance in practice, which states that “physicians

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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.

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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.”<sup>12</sup> 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.

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.<sup>12</sup>

**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.

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## 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.<sup>13-14</sup> 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.<sup>15</sup> 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 than their less-experienced counterparts even after adjusting for patient volume.<sup>16</sup>

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.<sup>11,16-17</sup> 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

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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.

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guiding state medical boards, these data could potentially be used to develop and refine reentry program curricula and assessment methods.

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

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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

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**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.**

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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.

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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# Physicians Reentering Clinical Practice: Characteristics and Clinical Abilities

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**INTRODUCTION:** Limited information exists to describe physicians who return to practice after absences from patient care. The Center for Personalized Education for Physicians (CPEP) is an independent, not-for-profit organization that provides clinical competency assessment and educational programs for physicians, including those reentering practice. This article studies the medical licensure status, performance and correlates between physician characteristics and performance on initial assessment.

**METHODS:** Sixty-two physicians who left practice voluntarily and without discipline or sanction and who were returning to practice in the same discipline as their previous practice participated in the CPEP reentry program. Physicians completed an objective clinical skills assessment including clinical interviews by specialty-matched board-certified physicians, simulated patient encounters, a documentation exercise and a cognitive function screen. Physicians were rated from 1 (no or limited educational needs) to 4 (global, pervasive deficits). Performance scores were compared based on select physician characteristics.

**RESULTS:** Twenty-five (40.3 percent) participants were female; participants' average age was 53.7 years (female 48.1 years; male 57.5 years). Physicians left practice for family issues (30.6 percent), health issues (27.4 percent), retirement or nonmedical career change (17.7 percent), and change to medical administration (14.5 percent). Females were more likely than males to have left practice for child rearing ( $P < 0.0001$ ). Approximately one-quarter (24.2 percent) of participants achieved a performance rating of 1 (best-performing group); 35.5 percent achieved a rating of 2; 33 percent achieved a rating of 3; 6.5 percent achieved a rating of 4 (worst-performing group). Years out of practice and increasing physician age predicted poorer performance ( $P = 0.0403$ ,  $P = 0.0440$ ). A large proportion of physicians presenting without an active license achieved active licensure; how many of these physicians actually returned to practice is not known.

**DISCUSSION:** Physicians who leave practice are a heterogeneous group. Most participants' performance warranted some formal education; few demonstrated global educational needs. The data from this study justify mandates that physicians demonstrate competence through an objective testing process prior to returning to practice. Emerging patterns regarding the performance of the reentering physician may help guide future policy.

**Key Words:** reentry, return to clinical practice, demonstration of competence, licensure requirements, educational needs, clinical competence, physician workforce, physician shortage, self-assessment

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## Introduction

The American Medical Association (AMA) suggests that fewer than 10 percent of physicians were on inactive status in 2003;<sup>1</sup> this number rose to nearly 12 percent in 2007.<sup>2</sup> Physicians leave practice or become clinically inactive for a variety of reasons. Other than actual retirement, the reasons most often cited include care of family members, career and compensation dissatisfaction, health-related problems, pursuit of other careers and sexual harassment.<sup>3,4</sup>

Following a period of inactivity, some physicians reenter practice. A study of Arizona physicians who renewed their medical licenses between 2003 and 2006 showed that 604 (4.6 percent) reentered clinical practice during this three-year time period,<sup>5,6</sup> an annual return rate of approximately 1.5 percent. Using this estimate of an annual return rate of 1.5 percent, and an actively employed United States physician population of 661,400 (Bureau of Labor Statistics, 2008),<sup>7</sup> close to 10,000 physicians may be returning from inactive status each year. State licensure boards as well as hospital and other credentialing bodies are increasingly faced with the question of how to ensure that it is safe to allow these physicians to resume practice.

Many states have addressed concerns about the competence of the reentering physicians by establishing policies that regulate new licensure or reactivation of a medical license after a time away from practice, but these policies vary greatly. Thirty of 68 member boards in the Federation of State Medical Boards (FSMB) responding to an AMA survey<sup>8</sup> reported that they have a policy regarding physician reentry; an additional nine boards are in the process of developing a policy.<sup>8</sup> The duration of absence from clinical activity that causes a state licensure board to consider a physician as a reentry physician ranges from 1 to 5 years,<sup>8</sup> with 2 years or more being the most common criteria. The licensure boards also have varying requirements for the reentry physician to demonstrate competence for licensure, ranging from providing evidence of continuing medical education activity to completion of a formal reentry program.<sup>8</sup> The reason for this broad array of requirements may be that little is known about precisely how time away from practice impacts physician competency, what risk factors indicate a need for educational

remediation before or while returning to practice, and what kind of educational processes are effective in returning such physicians to practice.

There is limited published information about reentering physicians. The largest previously published study of reentry physicians in the United States is a study of 102 physicians who participated in a Medical College of Pennsylvania program between 1968 and 1976, published in 1978.<sup>9</sup> A follow-up study published in 1982 from the same program compared the participants from 1968–1975 and 1976–1981, which included a total of 181 participants (including the original 102 physicians).<sup>10</sup> Two studies about retraining such physicians were published in 1969 and 1972.<sup>11,12</sup> A resurgence of interest in physician reentry surfaced in the early 2000s, as indicated by a flurry of both scientific and lay press articles.<sup>3,13,14</sup> An article describing a program specifically for anesthesiologists to remediate or update their skills was published in 2006 and reviewed the experience of 25 physicians.<sup>15</sup> Respected professional organizations such as the American Academy of Pediatrics (AAP) and the AMA have expended effort gathering expertise and composing recommendations related to this topic. The AAP Division of Workforce and Medical

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### PHYSICIANS WHO LEAVE PRACTICE FOR A PROLONGED BREAK ARE A HETEROGENEOUS GROUP, THE MAJORITY OF WHOM DEMONSTRATE EDUCATIONAL NEEDS THAT WARRANT SOME STRUCTURED EDUCATION BEFORE REENTERING PRACTICE.

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Education Policy is the guiding force behind the Physician Reentry into the Workforce Project, a collaboration of several organizations that focuses on issues pertinent to reentering physicians (<http://www.physicianreentry.org/>). In 2008, the AMA Council on Medical Education released a report on physician reentry, which provided an overview of the status of reentry in the United States as well as 10 proposed guiding principles for physician reentry programs.<sup>5</sup> Notably, these guiding principles included a recommendation that the reentry programs have an objective mechanism to evaluate physician performance and that the programs are tailored to the needs of the individual physician.

The Center for Personalized Education for Physicians (CPEP) is an independent, not-for-profit organization founded in 1990. CPEP provides clinical competency assessments and educational programs for

physicians, including those returning to practice after an absence. CPEP programs are structured on the premises that education should be directed by an evaluation of the individual’s educational needs<sup>16,17</sup> and that traditional continuing medical education conferences alone may not be effective in improving practice.<sup>18</sup> This approach is consistent with that of remediation programs both in the United States and internationally.<sup>17,19</sup> Since 2003, CPEP has evaluated 62 reentry physicians and has assisted many of those who needed remediation through a structured educational process. This article describes the characteristics, participant performance, and licensure status of those physicians, and potential correlates among physician characteristics and between physician characteristics and performance on initial assessment. Finally, this article will discuss whether the performance ratings of these reentering physicians support licensing board requirements to demonstrate competence after a time away from practice.

**Methods**

The CPEP Reentry Program involves an initial skills assessment in the physician’s area of intended practice and, if education or remediation is indicated, a supportive and structured educational process that takes place while the physician returns to practice.

CPEP evaluated 62 reentry physicians and assisted a portion of those who needed remediation through a structured educational process. All participants in

this study were physicians (M.D. or D.O.). Physicians were eligible for this study if they left practice voluntarily, were under no state licensure board discipline or sanction, and were returning to practice in the same discipline as their previous practice.

At the time of enrollment, participants (*n* = 62) provided demographic information (gender, age), information about their licensure status, and information about their professional status (reason for leaving practice and time away from practice) with the use of self-report forms; if information in the written intake form was unclear or missing, CPEP staff clarified the information through discussion with the participant. Licensure status was tracked because most of the participants enrolled to comply with a board rule to demonstrate competence, and the immediate objective of these participants was to gain licensure or relicensure. CPEP confirmed the licensure status at the time of enrollment as well as current licensure status (May 2010).

The physicians completed a clinical skills assessment that included 2–3 90-minute interviews conducted by specialty matched board-certified physician consultants. In addition, the participants completed two (psychiatry) or three (all other specialties that involve patient contact) simulated patient encounters, a documentation exercise, cognitive function screen and, depending on the physician specialty, written testing. The number of interviews conducted varied due to changes to the reentry protocol as it evolved over time, and due to

**Table 1**  
**Factors considered in determining participant rating and description of educational processes**

Factors considered	Performance rating			
	1	2	3	4
Demonstrated readiness for practice	Yes	Yes, with educational support	Yes, with initial period of supervision	No
Extent of educational needs	None to minimal	Moderate	Extensive	Global
Recommended educational process	Independent on-going education	Preceptorship (case discussion, chart review)	Comprehensive specialty review	Training in residency setting
		Focused study (article review, CME)	Initial supervised practice (gradually increasing responsibility)	
		Medical information resources (Internet, hand-held devices)	Activities as described for rating 2	
Estimated duration of educational process	N/A	Two–four months	Four–nine months	Determined by residency

a specific request by a referring state medical board that applicants who had been out for more than 10 years undergo a more rigorous evaluation because of the length of time out of practice; CPEP ultimately adopted this protocol and began to recommend three interviews for physicians who had been out for more than 10 years. Of the 14 physicians in this study who had three clinical interviews, 10 were physicians who had been out of practice for more than 10 years; the other four underwent three interviews for reasons determined by CPEP. Forty-eight physicians completed two clinical interviews, including five participants who had been out of practice for more than 10 years. Factors considered in determining the performance ratings were demonstration of readiness for practice and the extent and characteristics of educational needs identified. Two CPEP physician reviewers and the Executive Director reviewed the data from each participant and reached concurrence regarding the factors.

Those physicians who demonstrated readiness to return to independent practice were rated a 1; physicians with global educational deficits needing residency education were rated a 4. Physicians rated 2 and 3 demonstrated moderate to extensive educational needs; for these physicians, CPEP recommended completion of a structured educational process, which might include focused study, coursework, preceptorship, or chart review. The primary difference in these ratings is that the latter had more extensive educational needs and, thus, more intensive education was recommended, including initial practice in a supervised setting with gradually

increasing independence. The factors considered in determining the performance rating and a brief description of the potential educational recommendations are elaborated in Table 1. A portion of the participants who completed the assessment component enrolled in the education component of the reentry program. SAS version 9.2 (The SAS Institute, Cary, NC) was utilized for all statistical tests. Fisher's exact tests were performed (see Table 2) to relate primary reason for leaving practice to gender. Reason for leaving practice was coded as a dummy variable for this analysis (0,1), and a

**CPEP'S ASSESSMENT OF REENTRY PHYSICIANS INDICATES THAT PHYSICIANS WHO LEAVE PRACTICE FOR A PROLONGED BREAK ARE A HETEROGENEOUS GROUP, THE MAJORITY OF WHOM DEMONSTRATE EDUCATIONAL NEEDS THAT WARRANT SOME STRUCTURED EDUCATION BEFORE REENTERING PRACTICE.**

separate test was run for each reason for leaving practice. In Tables 3 and 4, one-way analyses of variance (ANOVAs) utilizing the general linear models were employed to test the relationship between physician rating, time out of practice, and age. A multi-variate model was not tested because time out of practice and age were highly collinear variables. Fisher's exact test was performed to evaluate licensure status at the time of the initial assessment and assessment performance.

**Table 2**  
**Primary reason reported for leaving clinical practice by gender**

Primary reason for leaving practice	Female	Male	Total number of participants	P value* (Fisher's exact)
Administrative position	1	8	9 (14.5%)	0.0716
Personal: child rearing	14	3	17 (27.4%)	<0.0001
Personal: care of spouse	1	1	2 (3.2%)	1.00
Health: medical	6	8	14 (22.6%)	1.00
Health: psychiatric	1	2	3 (4.8%)	1.00
Nonmedical career	0	3	3 (4.8%)	0.2663
Personal: other	1	5	6 (9.7%)	0.3870
Retired	1	7	8 (12.9%)	0.1286
<b>Total</b>	<b>25</b>	<b>37</b>	<b>62</b>	

\*P value relating gender to primary reason for leaving practice.

## Results

### Description of participants

Twenty-five (40.3 percent) of the participants were female. Ages of the participants ranged from 31 to 73 years, with an average age of 53.7 years (female 48.1 years; male 57.5 years). The majority of the participants (49 or 79 percent) enrolled in the reentry program in order to demonstrate competency after time away from practice for a state licensure board; some came at the recommendation of a hospital (4, 6.5 percent) or other organization (4, 6.5 percent), and some were self-referred (5, 8.1 percent). The majority (46 or 74.2 percent) of physicians had either an inactive/lapsed/expired license or no license in the state in which they wished to enter practice at the time of enrollment.

Participants left practice for a variety of reasons, such as family issues including care of family members (30.6 percent) [child-rearing 27.4 percent; care of a sick spouse 3.2 percent], health issues (27.4 percent), retirement or leaving medicine to pursue a different career (nonmedical career change [17.7 percent]), and to assume a medical administrative position (14.5 percent) (see Table 2). When comparing reasons for leaving practice to gender, the data showed that females were more likely than males to leave practice for child-rearing purposes ( $P < 0.0001$ ). The association between leaving for an administrative position and gender approached significance ( $P=0.072$ ) with males choosing this route more often than females.

The time out of practice averaged 8.1 years, and ranged from 1.5 years to 23 years. Participants were preparing to return to a variety of specialties, including primary care (internal medicine, family

medicine, pediatrics, and general practice) (48.4 percent), surgery and surgical specialties (14.5 percent), psychiatry (9.7 percent), obstetrics/gynecology and subspecialties (6.5 percent), internal medicine subspecialties (6.5 percent), anesthesiology (4.8 percent), and others (9.7 percent).

### Participant performance

Approximately one-quarter of participants (15, 24.2 percent) achieved a performance rating of 1 during their assessment; 69.4 percent demonstrated a performance rating of 2 (22, 35.5 percent) or 3 (21, 33.9 percent), and a small portion of the participants (4, 6.5 percent) achieved a performance rating of 4. Participant performance was also analyzed based on time away from practice and the results are shown in Table 3. Years out of practice was significantly related to performance rating ( $P = 0.0403$ ).

Physician performance ratings were also analyzed based on participant age category (see Table 4). Physician age category was significantly related to performance rating ( $P= 0.0440$ ) with older physicians more likely to have higher ratings. There was no significant relationship between licensure status at the time of the assessment and performance in this small data set ( $P = 0.4641$ ).

### Licensure status and practice outcomes

Licensure status was determined based on the state in which the physician reported that he/she intended to seek licensure or practice. Licensure status at the time of presentation was compared to current licensure status (May 2010). CPEP was able to confirm the accuracy of the self-reported status for 46 (74.2 percent) of physicians; because of the

**Table 3**  
Rating on assessment by years out of practice: range of performance and average rating

Years out of practice	Number of participants to achieve each rating				Total	Average rating
	1	2	3	4		
1–5 years	7 (36.8%)	5 (26.3%)	7 (36.8%)	0	19	2.00
6–10 years	6 (21.4%)	13 (46.4%)	7 (25%)	2 (7.1%)	28	2.18
11–15 years	2 (20%)	2 (20%)	5 (50%)	1 (10%)	10	2.50
>16 years	0	2 (40%)	2 (40%)	1 (20%)	5	2.80
<b>Total</b>	<b>15</b>	<b>22</b>	<b>21</b>	<b>4</b>	<b>62</b>	<b>2.23</b>

Note: Years out of practice is significantly related to physician rating ( $P = 0.0403$ ) with the use of a general linear model in SAS version 9.2.

way licensure status is recorded on some board Web sites, CPEP was not able to confirm initial status for the remaining 16 physicians. CPEP staff confirmed the current (May 2010) licensure status for all physicians. Licensure status is presented in Table 5.

At this time, CPEP does not know whether physicians who did not have continued involvement with CPEP education programs have actually returned to practice. For the 22 physicians who enrolled in the education component of the reentry program, 16 completed their educational process, and each of these physicians was in active practice during and at the completion of the educational process. An additional three physicians are currently enrolled, two of whom are actively engaged in practice. Three physicians withdrew prior to completion of the program.

### Discussion

The authors believe that this article provides information about the largest series of reentering physicians since the description of physicians reentering practice through the Medical College of Pennsylvania program, published in 1982.<sup>10</sup>

CPEP's assessment of reentry physicians indicates that physicians who leave practice for a prolonged break are a heterogeneous group, the majority of whom demonstrate educational needs that warrant some structured education before reentering practice. In this data set, approximately two-thirds of participants currently have active licenses in comparison to 25 percent at enrollment, indicating that they have been able to address licensing board requirements. Most of the physicians who completed the education components and for whom follow-up data were available achieved their stated goal of returning to practice.

### Characteristics of reentry physicians and their reasons for leaving practice

Among CPEP reentry program participants, approximately 12.9 percent left practice intending to retire, whereas 4.8 percent left medicine to pursue a nonmedical career. Another 14.5 percent left practice for a nonclinical medical administrative role. Male physicians *may* be more likely to leave for a medical administrative role than females. Seventeen percent of participants cited child rearing as their reason for leaving practice. Female physicians in this group were statistically more likely to leave practice for child rearing than their male counterparts.

Physical and mental health conditions are cited as reasons that physicians might require prolonged absences from clinical practice. CPEP findings were similar to a study of Australian nurses returning to practice, in which health of the individual or a family member was implicated in 16 of 69 cases (23.2 percent).<sup>20</sup> In the CPEP study, 27.4 percent of physician reentry candidates indicated that personal health conditions were the reason that they left practice. The majority of the health conditions were physical health conditions including stroke, closed head injury, and multiple sclerosis, rather than mental

**Table 5**  
Licensure status

Performance rating	Active license at enrollment		Active license May 2010	
All participants	16	(25%)	41	(66%)
1	5	(33%)	14	(93%)
2	4	(18%)	15	(68%)
3	5	(24%)	11	(52%)
4	2	(50%)	1	(25%)

**Table 4**  
Rating on assessment by participant age

Age	Number of participants to achieve each rating				Total	Average rating
	1	2	3	4		
30–39 years	1 (20%)	2 (40%)	2 (40%)	0	5	2.20
40–49 years	6 (40%)	6 (40%)	3 (20%)	0	15	1.80
50–59 years	4 (16%)	11 (44%)	10 (40%)	0	25	2.24
60–69 years	3 (25%)	3 (25%)	5 (41.7%)	1 (8.3%)	12	2.33
70–79 years	1 (20%)	0	1 (20%)	3 (60%)	5	3.20
<b>Total</b>	<b>15</b>	<b>22</b>	<b>21</b>	<b>4</b>	<b>62</b>	<b>2.23</b>

Note: Age category is significantly related to physician rating (P = 0.0440) with the use of a general linear model in SAS version 9.2.

health conditions. Psychiatric conditions included depression and substance abuse. CPEP excluded physicians from the program who had disciplinary board stipulations or orders; therefore, physicians who had discipline related to health conditions such as substance abuse were excluded from this study.

### Participant performance

Approximately one-quarter of the physicians who completed the clinical skills assessment demonstrated minimal educational needs and were adequately prepared for a return to independent practice at the time of the assessment. The majority (67 percent) were found to have educational needs requiring moderate to considerable reeducation or updating and another 6.5 percent showed educational needs that were broad enough to recommend education in a residency program to prepare for a return to practice (performance rating of 4). These data tend to confirm the concern of licensure boards that many reentering physicians may not be ready to jump back into practice; they also tend to justify mandates that physicians demonstrate competence through an objective testing process prior to returning to practice.

### Participant licensure and return to practice

The primary reason that physicians enrolled in the CPEP Reentry Program was to meet state board licensure requirements. This study found that many of the participants who presented to the program without an active license went on to obtain a license. This study did not include specific follow-up with participants to determine whether they actually returned to practice. There was a relatively small subset of physicians who participated in a structured educational process with CPEP and for whom data were available to suggest they were successful in returning to practice. It is not yet clear whether a physician's demonstrated abilities and readiness to return to practice can be predicted. Other studies have shown a correlation between increasing age and poor performance on competency assessment in different physician populations.<sup>19, 21-23</sup> The data presented here support similar conclusions for the reentry physician population. This data also indicate that time away from practice correlated with worse performance. If additional studies confirm these trends, licensing boards may choose to consider varying requirements, based on time away from practice and/or the age of the physician. Interestingly, there was no significant relationship between initial license status at the time of presentation and performance in this dataset; thus, having an active license at the time of reentry did not correlate with better performance in the CPEP program. This may be relevant as

boards begin to consider how to regulate the inactive physician who has maintained an active license.

### Limitations

This study is limited by the relatively small number of physicians studied, which may have impacted the ability to identify statistical significance with some variables. Some of the physician characteristics reported are self-reported, such as the reason for leaving practice. The extent of educational activities undertaken by the participant prior to enrollment was not evaluated. Although CPEP encouraged participants to prepare prior to the reentry assessment, this was left up to the individual participants. Therefore, the authors cannot comment on the possible impact of individual preparation on performance. With consideration for the developing nature of the CPEP process, including individualization of assessment, each physician did not undergo exactly the same evaluation process, such as two versus three interviews. CPEP utilizes oral interviews in the evaluation of physicians, which allows for tailoring an evaluation to the physician; such interviews can be criticized due to potential subjectivity. CPEP strives to address this in its training processes and assessment structure.

### Implications

Physicians have been shown to be poor at analyzing their educational needs, and the more significant the physician's needs, the more significant the discrepancy in self-perceived versus actual educational needs.<sup>24</sup> This suggests that it may be difficult for physicians returning to practice to plan for and gauge their

### Lessons for practice

- Through an objective assessment of competence, physicians returning to practice can be assisted in identifying gaps in knowledge prior to their return to patient care.
- A majority of participants who enrolled in the Center for Personalized Education for Physicians (CPEP) reentry program demonstrated moderate to significant educational needs.
- Physicians who participated in a supportive, structured educational program were generally successful in achieving their goal of restoring licensure and returning to practice.
- Emerging patterns indicate that certain physician characteristics (age, time away from practice) may help predict performance.

readiness for return accurately. Licensing board mandates that require a reentry physician to demonstrate competency through an objective assessment process prior to consideration for licensure or reactivation of licensure, and to follow through with educational recommendations, create barriers of time and cost for the reentering physician. However, the first priority of the licensing boards is patient safety, and the boards must create policies that are consistent with the mission of ensuring the competence of licensees.<sup>25</sup> Assessed competency with educational recommendations appears justified, based on the findings of this study. Further analysis of potential correlates with performance may allow more tailored approaches based on physician characteristics or circumstances.

### Unanswered questions and future research

Especially in light of growing concerns about the physician workforce,<sup>26,27</sup> the issue of physicians returning to clinical practice after a prolonged absence is of major importance. The magnitude of the phenomenon of physician reentry is uncertain, but it may include thousands of physicians each year. Though many state licensure boards and hospitals have established policies to manage reentry physicians, the policies vary significantly from state to state regarding the duration of absence from practice that would trigger a reentry process, acceptable options to demonstrate competence, and the educational process required prior to licensure or reactivation.<sup>8</sup>

It is not yet clear whether a physician's demonstrated abilities and readiness to return to practice can be predicted, but data from this study show a relationship between time away from practice and increased age and poorer performance. Additional study is warranted to learn more about the reentry physician and potential predictors of performance.

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Australia

**Australian Medical Council Highlights Improvements to Accreditation and Assessment Programs**

The Australian Medical Council (AMC) recently released highlights of its accreditation and assessment programs over the last year.

Early in 2011, AMC announced that it had transitioned its accreditation and assessment programs into Australia's national registration process — a key development in Australia's move toward national regulation through a comprehensive reorganization of its former system.

The new process, known as the National Registration and Accreditation Scheme (NRAS), was formally adopted in 2010.

Highlights of the year include:

- A number of initiatives aimed at improving services for International Medical Graduates (IMGs), including complete review and evaluation of the assessment pathways for IMGs introduced nationally three years ago and planning for the expansion and improvement of its Multiple Choice Question (MCQ) and Clinical Examinations for IMGs.
- Improvements to AMC's standardized MCQ Examination, including a new computer-adapted version aimed at streamlining the administration of the examination. According to AMC, the revised examination will "significantly increase the AMC's capacity to deliver a reliable and secure written examination."
- A significant increase in clinical examination capacity, with more than 1,000 candidates able to participate in the clinical examination during the year. According to AMC, the capacity to deliver clinical examinations has been limited by the availability of suitable clinical examination venues, numbers of examiners, role-playing, and real patients. AMC is now conducting clinical examinations every two weeks throughout the year. AMC is investigating opportunities to

"further increase available places and developing innovative examination methodology while maintaining the integrity of the assessment." ■

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Source: Australian Medical Council website, June 2011

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Canada

**New Objectives for Canada's Qualifying Examination Online Web Service**

An updated edition of the Medical Council of Canada (MCC) publication, "Objectives for the Qualifying Examination," is now available for medical graduates entering practice in Canada. The Objectives outline MCC's proficiency expectations of medical graduates.

The third edition of the Objectives, which was first published in December 2004 and has been periodically updated, serves as the basis for MCC examinations. Canadian medical schools use the Objectives to plan curriculum and they are used by medical experts and assessment organizations to prepare examination content. Candidates preparing to take MCC examinations can refer to the Objectives as a study guide.

MCC has announced a new online web service that will provide better navigation and easier access to the Objectives for all users by allowing the content to be searchable by computer applications.

To learn more about the Objectives, visit [www.mcc.ca/Objectives\\_Online](http://www.mcc.ca/Objectives_Online). ■

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Source: Medical Council of Canada website, June 2011

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Global Organizations

**IAMRA 2012 Conference Dates and Location Announced**

The International Association of Medical Regulatory Authorities (IAMRA) has announced dates and location for its 2012 International Conference on



Medical Regulation. The conference will be held at the Ottawa Convention Centre in Ottawa, Ontario, Canada, October 2–5, 2012.

The 2014 International Conference on Medical Regulation will be held in September 2014 in London, England.

IAMRA staff and members are at work on the next version of a set of foundational principles that will be used to develop international best practices in medical regulation. The foundational principles were initially compiled during the group’s last international meeting, held in the United States in late 2010.

More than two hundred participants, representing 90 organizations from 32 countries, worked together in interactive, small-group sessions to identify the principles that will help drive a more targeted set of best practices. The principles establish such attributes as fairness, innovation, relevance, portability, transparency, feasibility and others as vital components in best practices.

For more information about IAMRA, please visit [www.iamra.com](http://www.iamra.com). ■

Sources: IAMRA website, June 2011; FSMB *Newsline*, Fall 2010

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**United Kingdom**

**Revalidation Guidelines in UK to Help Physicians Prepare for Performance Assessment Process**

The United Kingdom’s General Medical Council (GMC) is continuing to move forward with its “revalidation” concept—the UK’s equivalent of the Maintenance of Licensure concept in the United States—launching a basic guideline to appraisals for physicians who will need to comply with the new system starting at the end of 2012.

The guidelines provide background for physicians to help them adhere to the professional standards that make up the core of the revalidation concept.

Health care employers in the UK are being asked to make sure that every physician has access to the guidelines as the entire UK health system adapts to revalidation.

At the heart of the new system is a set of ethical principles referred to as “Good Medical Practice” and a framework for self-assessment. UK physicians will be asked to discuss how they have met these core principles during periodic appraisals to assess their practice.

Physicians will use a four-step process during their assessments, according to the GMC:

- Reflect on your practice and your approach to medicine.
- Reflect on the supporting information you have gathered and what that information demonstrates about your practice.
- Identify areas of practice where you could make improvements or undertake further development.
- Demonstrate that you are up to date and fit to practice.

When revalidation is introduced, every physician will be required to bring supporting information to their periodic appraisals that demonstrates that they are keeping up to date.

According to the GMC, they will also be expected to seek feedback from patients and colleagues, and they should be able to show that they take part regularly in activities that evaluate the quality of their work, such as clinical case reviews or the review of clinical outcomes.

The GMC worked closely with a number of organizations to develop the framework, including the four UK health departments and the Academy of Medical Royal Colleges. Niall Dickson, the Chief Executive of the GMC, said an effort had been made to keep the appraisal process “realistic and straightforward.” “We want appraisals to be rewarding and useful, not time-consuming or difficult,” he said. ■

Source: General Medical Council website, June 2011

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California

**California Regulatory Groups Consider  
Reclassification to Recognize  
Podiatrists as Physicians**

The California Medical Association (CMA), the California Orthopaedic Association (COA) and the California Podiatric Medical Association (CPMA) have announced a joint task force to review the education, curriculum and training of California's podiatric medical schools with the ultimate goal of accrediting them as full-fledged allopathic medical schools.

It is the first agreement of its kind anywhere in the nation, according to the CMA.

The joint task force will examine current podiatric medical school standards and curriculum in the state, hoping to create podiatric training programs

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THE GOAL, ACCORDING TO CMA, IS TO PREPARE  
PODIATRIC STUDENTS 'TO BE LICENSED AS  
PHYSICIANS AND SURGEONS IN CALIFORNIA  
AND PROVIDE PATIENTS IN CALIFORNIA  
WITH THE HIGHEST QUALITY OF CARE.'

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that are equivalent to that of medical school for physicians and surgeons. The goal, according to CMA, is to prepare podiatric students "to be licensed as physicians and surgeons in California and provide patients in California with the highest quality of care."

The task force was created with the expectation that the California podiatric medical schools will be accredited by the Liaison Committee on Medical Education (LCME), a nationally recognized accrediting authority for medical education programs leading to the M.D. degree in U.S. and Canadian medical schools.

"Throughout this process, CPMA has made the strong case that the education and training of doctors of podiatric medicine have evolved and become

increasingly similar to that of medical doctors," said CPMA Executive Director Jon Hultman.

"We're excited to be a part of this unprecedented partnership," said CMA Chief Executive Officer Dustin Corcoran. "The licensure requirements of podiatrists have increased in California in recent years, and the time has come to evaluate their training programs in this context. The California Medical Association is looking forward to working with the COA and the CPMA to fully evaluate the education and training of podiatrists to identify and remove any remaining deficiencies so that future podiatric medical graduates would simply be medical school graduates." ■

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Source: California Medical Association website, June 2011

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Iowa

**Iowa Board of Medicine Celebrates  
125th Anniversary**

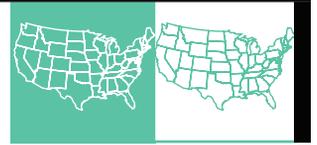
The Iowa Board of Medicine plans to observe its 125th anniversary this year with two special events, starting with a public meeting and reception July 29, 2011 in Iowa's "Old Capitol," located in Iowa City. The Board will convene in the Senate chamber of Old Capitol at 9:30 a.m. for a meeting to conduct routine work, with a reception to follow at 11 a.m.

An open house will be held on the afternoon of September 22, 2011, in the Board's office in Des Moines.

The State Board of Medical Examiners was established on July 1, 1886, to license and regulate physicians. In 1994, the Board assumed responsibility for registering acupuncturists, and subsequently the licensure and regulation of acupuncturists in 2000 when the law was changed. In 2007, the board's name was changed to the Iowa Board of Medicine. ■

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Source: Iowa Board of Medicine website, June 2011



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Maine

**Maine Prescription Monitoring Program Managed by New Vendor**

The prescription monitoring program (PMP) for the State of Maine is now hosted by a new vendor, Health Information Designs, Inc. (HID). Physicians already authorized to access Maine’s PMP database who visit the database online are being notified of the changeover and given instructions for accessing and logging on to the new PMP.

The Maine Board of Licensure in Medicine reports that diversion of prescription opiates is a serious and growing problem in the state. Data from the State Medical Examiner’s office indicates that accidental overdose due to opiates has been rising in recent years and that nearly all accidental deaths (94 percent) are caused by at least one prescription drug.

To help physicians who are asked to undertake the difficult task of managing pain while recognizing addiction and preventing diversion, the Maine Office of Substance Abuse (OSA) offers two types of free reports through its PMP database. Solicited reports are provided when a registered clinician queries the database online to obtain an immediate report on all Schedule II, III and IV prescription medications dispensed to a patient and how the patient paid for these medications. Unsolicited “threshold” reports are sent to physicians who have prescribed for a patient whose profile exceeds threshold indicators that suggest a possible problem with prescription medications. The threshold reports are generated quarterly.

To learn more about Maine’s PMP, visit [www.hidinc.com/mainepmp](http://www.hidinc.com/mainepmp). ■

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Source: Maine Board of Licensure in Medicine website, June 2011

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North Carolina

**NCMB Launches Task Force to Evaluate Its Position on Self-Treatment**

The North Carolina Medical Board (NCMB) has established a task force to revisit the Board’s position statement on the issue of treating self, close family members and other loved ones. The effort will include a public meeting at NCMB’s offices in Raleigh to discuss the position statement and consider possible changes.

North Carolina’s current position statement, titled “Self-treatment and the treatment of family members and others with whom significant emotional rela-

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‘...PHYSICIANS SHOULD NOT TREAT, MEDICALLY OR SURGICALLY, OR PRESCRIBE FOR THEMSELVES, THEIR FAMILY MEMBERS, OR OTHERS WITH WHOM THEY HAVE SIGNIFICANT EMOTIONAL RELATIONSHIPS.’

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tionships exist,” was adopted in May 1991. It was subsequently updated in 1996, 2000, 2002 and 2005. The position cautions against self-treatment and the treatment of loved ones, except for minor, acute illnesses or in emergency situations.

The board launched the task force after finding that “many licensees are unaware of the position statement and others find it vague and confusing.”

The current position statement offers this guidance for North Carolina physicians:

“It is the position of the North Carolina Medical Board that, except for minor illnesses and emergencies, physicians should not treat, medically or surgically, or prescribe for themselves, their family members, or others with whom they have significant emotional relationships. The Board strongly believes that such treatment and prescribing

practices are inappropriate and may result in less than optimal care being provided. A variety of factors, including personal feelings and attitudes that will inevitably affect judgment, will compromise the objectivity of the physician and make the delivery of sound medical care problematic in such situations, while real patient autonomy and informed consent may be sacrificed.”

“When a minor illness or emergency requires self-treatment or treatment of a family member or other person with whom the physician has a significant emotional relationship, the physician must prepare and keep a proper written record of that treatment, including but not limited to prescriptions written and the medical indications for them. Recordkeeping is too frequently neglected when physicians manage such cases.”

“The Board expects physicians to delegate the medical and surgical care of themselves, their families and those with whom they have significant emotional relationships to one or more of their colleagues in order to ensure appropriate and objective care is provided and to avoid misunderstandings related to their prescribing practices.” ■

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Source: North Carolina Medical Board website, June 2011

### **NCMB Adopts Rules for Physician Reentry**

The North Carolina Medical Board has adopted administrative rules that set out its expectations for licensees who wish to resume practice.

In North Carolina, a physician or physician assistant must complete a program of reentry if he or she is applying for a license to practice in the state and has not actively practiced or “has not maintained continued competency, as determined by the board, for the two-year period immediately preceding the filing of an application.” The board states that the “purpose of such a program is to demonstrate that the applicant is competent in his or her intended

area of practice.”

The board adopted a position statement on reentry in 2006 titled “Competence and reentry to the active practice of medicine,” which states the board’s expectation for reentry candidates to develop a satisfactory reentry program.

The state’s reentry rules standardize the board’s reentry program by listing specific factors that affect the terms of an individual’s reentry program.

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**THE STATE’S REENTRY RULES STANDARDIZE THE BOARD’S REENTRY PROGRAM BY LISTING SPECIFIC FACTORS THAT AFFECT THE TERMS OF AN INDIVIDUAL’S REENTRY PROGRAM.**

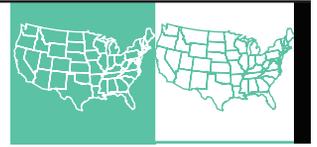
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These factors include the length of time out of practice, the prior intensity of practice, the skills needed for the intended area of practice, the reason for the interruption in practice and the licensee’s activities during the interruption in practice, including the amount of practice-relevant CME completed.

The rules also define a reentry program as consisting of a multi-phase period of mentoring under a physician approved by the board. Phases of the program include an observation phase, during which the reentry candidate observes his or her mentor in practice; a phase during which the reentry candidate practices under their mentor’s direct supervision; and a final phase during which the reentry candidate practices under the mentor’s indirect supervision. ■

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Source: North Carolina Medical Board Newsletter: 2011, No. 1



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Oregon

**Oregon Welcomes New Medical School — Second in the State**

The first class of students will begin studies soon at Oregon’s newest medical school — Western University’s College of Osteopathic Medicine of the Pacific (COMP) Northwest. The new program is the first medical school to open in Oregon in 100 years. The other is at the University of Oregon.

The campus, located in Lebanon, Oregon, will open in August 2011 with a class of 100 students scheduled to graduate in 2015. According to the Oregon Medical Board (OMB), entrance into the class has been competitive, with more than 2,500 applications.

At full capacity, the school will serve 400 students, most of whom will be from the Pacific Northwest. Graduates will complete residencies and begin entering the workforce as early as 2018.

COMP began in Pomona, California, in 1977 and is expanding into Oregon with its new Northwest campus. The new school will occupy a 54,000 square foot building, where it will stream online lectures and provide interface with students and faculty at the Pomona campus. ■

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Source: Oregon Medical Board *Report*, Spring 2011

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Texas

**Texas Effort to Crackdown on Illegal Pain Clinics Continues**

The Texas Medical Board (TMB) reports that it has suspended or cancelled the certifications of eleven pain clinics, while taking action against scores of individuals for pain medication-related violations, as it continues its sweeping initiative to curb so-called “pill mills” in the state.

In a high-profile arrest this spring, the Drug

Enforcement Agency (DEA) apprehended Houston physician Gerald Ratinov, M.D., and 18 other co-conspirators. According to the DEA, Dr. Ratinov was the most frequent prescriber of hydrocodone in the state.

Texas lawmakers adopted a bill in 2010 that significantly strengthened regulation of pain clinics, including a stipulation that pain clinics must be owned and operated by Texas-licensed physicians, who must register with the TMB. Pain clinic ownership certificates are not transferable or assignable.

The bill also tightened up background requirements of the owners of pain clinics, including a provision that owners must not have been subject to disciplinary action by any licensing entity for conduct that was a result of inappropriately prescribing, dispensing, supplying or selling a controlled substance. Under the bill, medical directors of pain clinics must ensure on an annual basis that their personnel are properly licensed and are trained in pain management. ■

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Source: Texas Medical Board *Bulletin*, May 2011 and Spring 2010

**Sheriff Convicted in Medical Whistleblower Case in Texas**

Sheriff Robert L. Roberts Jr. of Winkler County, Texas, has been convicted of taking retaliatory actions against two nurses who complained to the Texas Medical Board (TMB) about a physician who is a friend of his.

Jurors returned guilty verdicts on four felony counts and two misdemeanor charges.

Anne Mitchell and Vickilyn Galle had reported the physician they worked for, Rolando Arafiles, Jr., MD, to TMB, accusing him of using herbal remedies and inappropriate use of hospital supplies.

Their letter was unsigned, but when Dr. Arafiles found out about it, he asked Roberts to investigate, saying he was being harassed. The women were



later fired from the hospital and charged with felonies for misuse of official information. One of the two was acquitted and charges against the other were dropped.

Later, they sued the county, the hospital, Roberts and others, charging that their prosecutions had been vindictive, and won a \$750,000 settlement. In February, TMB placed Dr. Arafiles on probation for four years.

Sheriff Roberts was fired as a result of the convictions. He was sentenced to 100 days in jail, four years of probation and was fined \$6,000.

“The verdict sends a message that nurses, patients and family members can bring a complaint about a doctor to the Texas Medical Board without fear of retaliation,” TMB Executive Director Mari Robinson told the Associated Press.

Health care associations across the nation had watched the case closely and publicly commented on it, saying it was a key test of physician accountability and that it had the potential to put a chilling effect on nurses and others who wanted to report unethical or illegal activity in the workplace. ■

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Source: Associated Press, June 14, 2011

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**Virginia**

**Requests for Data Using Virginia Prescription Monitoring Program Up Dramatically in Last Two Years**

The Virginia Board of Medicine reports that requests for reports through the Virginia Prescription Monitoring Program (PMP) have grown from 75,000 in 2009 to more than 433,000 requests in 2010. Prescribers and pharmacists account for 98 percent of all requests to the program, according to the board. The program anticipates processing more than 600,000 requests in 2011.

According to the board’s website, “abuse and

diversion remain realities in the Commonwealth, and deaths from prescription drugs continue at an alarming rate.”

Prescribers in Virginia are encouraged to use the Prescription Monitoring Program to access information about patients for whom they prescribe or anticipate prescribing Schedule II-IV controlled substances. Patient consent is no longer required to access this data in Virginia; however, patients must be informed that a provider might check their data.

Virginia’s PMP was upgraded in 2009 to provide round-the-clock access with auto-response

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**‘ABUSE AND DIVERSION REMAIN REALITIES IN THE COMMONWEALTH, AND DEATHS FROM PRESCRIPTION DRUGS CONTINUE AT AN ALARMING RATE.’**

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software. According to the board, the number of prescribers registered to use the program has more than doubled since the installation of the new software two years ago.

Approximately 1,900 resident pharmacies, non-resident pharmacies and dispensing physicians submit prescription records for Schedule II-IV drugs each month in Virginia. The program database holds more than 60 million prescriptions, which supply the data for almost 2,000 daily reports in response to requests from 7,600 prescribers and 1,600 pharmacists who use the information to make treatment and dispensing decisions.

To learn more, visit [www.dhp.virginia.gov/medicine](http://www.dhp.virginia.gov/medicine). ■

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Source: Virginia Board of Medicine website, June 2011



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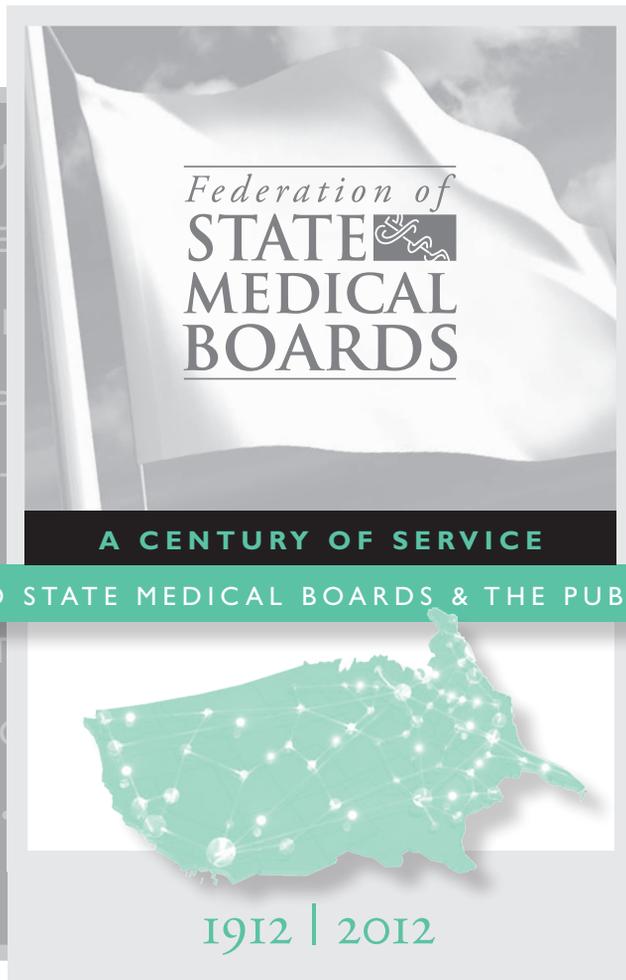
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2. The title page should contain only the title of the manuscript. A separate list of all authors should include full names, degrees, titles and affiliations.
3. The manuscript pages should be numbered, and length should be between 2,750 and 5,000 words, with references (in Associated Press style) and tables attached.
4. The manuscript should include an abstract of 200 words or less that describes the purpose of the article, the main finding(s) and conclusion. Footnotes or references should not be included in the abstract.
5. Any table or figure from another source must be referenced. Any photos should be marked by label on the reverse side and “up” direction noted. Tables and figures can be supplied in EPS, TIF, Illustrator, Photoshop (300 dpi or better) or Microsoft PowerPoint format.
6. The number of references should be appropriate to the length of the text, and references should appear as endnotes, rather than footnotes.
7. Commentary, letters to the editor and reviews are accepted for publication. Such submissions and references should be concise and conform to the format of longer submissions.
8. If sent by mail, a PC- or Mac OS-compatible CD-ROM should accompany a printed copy of the manuscript. Microsoft Word format is the preferred file format.
9. Manuscripts are reviewed in confidence. Only major editorial changes will be submitted to the corresponding author for approval. The original manuscript and CD-ROM will be returned if the submission is not accepted for publication only if a SASE is supplied with sufficient postage.



## Help us commemorate FSMB's Centennial in 2012!

Preparations are under way to celebrate the Federation of State Medical Boards' Centennial year in 2012. The year-long celebration of the FSMB and all state medical boards will include:

- A written history of the FSMB
- Historical highlights of each state medical board
- Special events at the 2012 FSMB Annual Meeting in Fort Worth, Texas
- Website content commemorating medical regulation over the last century

The FSMB welcomes the submission of any historical materials that could help document and celebrate the accomplishments of the FSMB and the important work of state medical boards. Materials could include photographs, copies of key archival documents, articles, personal memoirs and previously written medical board histories. **Your contributions are greatly appreciated.**

Historical materials may be sent to:  
**Linda Jordan**, Librarian  
Federation of State Medical Boards  
400 Fuller Wisser Road, Suite 300  
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or by e-mail to [ljordan@fsmb.org](mailto:ljordan@fsmb.org).

For more information about the FSMB Centennial Project, please contact:  
**David Johnson**, [djohnson@fsmb.org](mailto:djohnson@fsmb.org) or (817) 868-4081.

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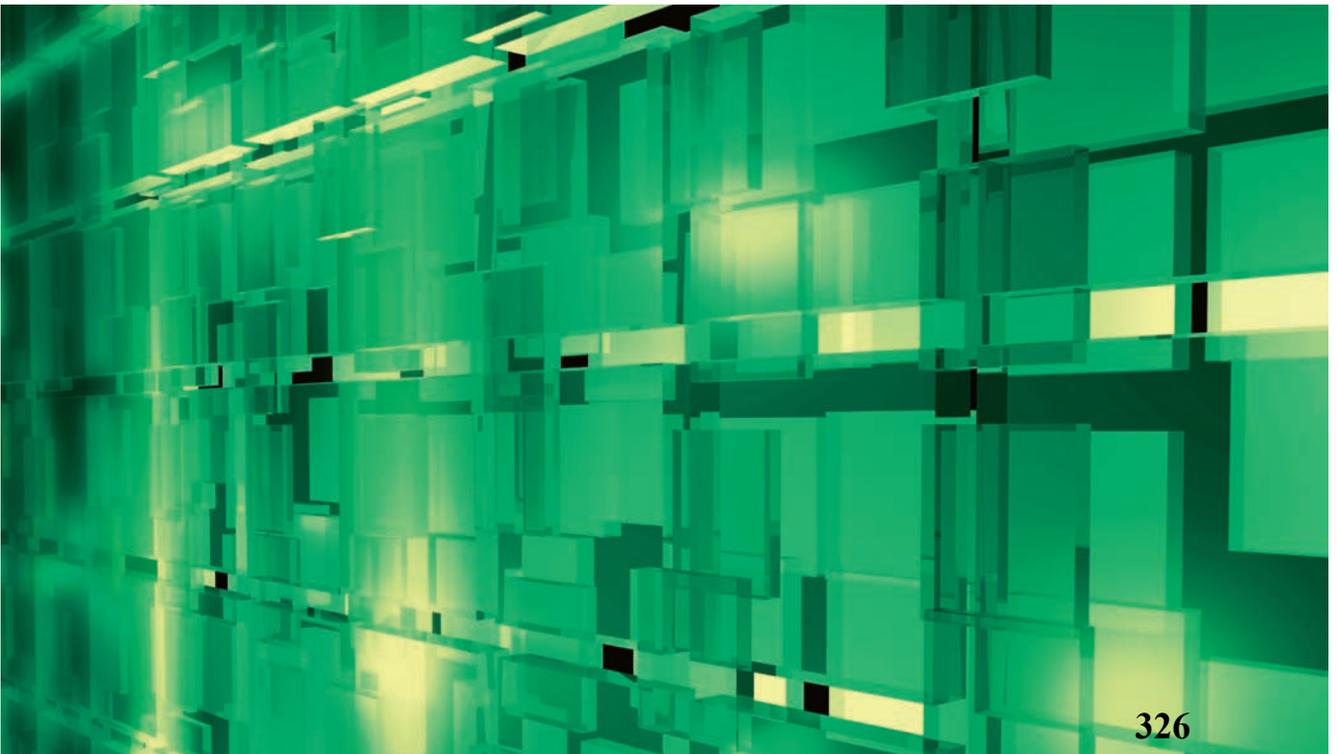
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# Report of the Special Committee on Reentry to Practice

Adopted as policy by the Federation of State Medical Boards in 2012

## Table of Contents

<i>EXECUTIVE SUMMARY</i> .....	5
<i>INTRODUCTION AND CHARGE</i> .....	6
<i>NEED FOR REENTRY GUIDELINES FOR STATE MEMBER BOARDS</i> .....	7
<i>KEY REENTRY ISSUES</i> .....	8
<i>INPUT FROM ADVISORS</i> .....	100
<i>ROLE OF STATE MEMBER BOARDS IN REENTRY</i> .....	100
<i>SUGGESTED REENTRY GUIDELINES</i> .....	111
<i>EDUCATION AND COMMUNICATION ISSUES</i> .....	12
<i>DETERMINING FITNESS TO REENTER PRACTICE</i> .....	122
<i>MENTORING FOR PRACTITIONERS WHO WANT TO REENTER THE WORKFORCE</i> .....	155
<i>IMPROVING REGULATION OF LICENSED PRACTITIONERS WHO ARE CLINICALLY INACTIVE</i> .....	155
<i>RELATIONSHIP BETWEEN LICENSURE AND SPECIALTY CERTIFICATION</i> .....	166
<i>IMPLICATIONS FOR STATE MEMBER BOARDS AND THE ROLE OF FSMB</i> .....	166
<i>CONCLUSION AND NEXT STEPS</i> .....	177
<i>ATTACHMENT A: SPECIAL COMMITTEE DESIRED OUTCOMES; THE AUDIENCE, SCOPE AND ORGANIZATION OF THE SPECIAL COMMITTEE REPORT</i> .....	18
<i>ATTACHMENT B: GLOSSARY</i> .....	200
<i>ATTACHMENT C: REENTRY BARRIERS</i> .....	22
<i>ATTACHMENT D: FSMB MAINTENANCE OF LICENSURE FRAMEWORK</i> .....	25
<i>ATTACHMENT E: STATE MEMBER BOARD RESOURCES</i> .....	266
<i>ATTACHMENT F: ADDITIONAL LITERATURE ON REENTRY</i> .....	35
<i>ENDNOTES</i> .....	36

## EXECUTIVE SUMMARY

In 2010, the Federation of State Medical Boards (FSMB) formed a Special Committee on Reentry to Practice and charged it with issuing recommendations to the FSMB Board of Directors concerning physician and physician assistant reentry to the clinical practice of medicine. It is reported that a growing number of physicians have or will take a temporary leave from the practice of medicine. Physicians may take a temporary leave from practice for multiple reasons, including personal lifestyle decisions, or to pursue research, administrative or other professional interests not involving the clinical practice of medicine.

Regardless of the reasons for an interruption in clinical practice, it is critical for state medical and osteopathic boards (hereafter referred to as state member boards or SMBs), to address physician and physician assistant reentry as part of their mission to insure patient safety. As part of this mission, state member boards should provide a standardized process for physicians and physician assistants, who may take a temporary leave from practice, to demonstrate their competence prior to reentering practice. State member boards should also be aware that physician reentry may offer an additional means of addressing the anticipated national physician shortage.

The Special Committee recognizes that physician reentry can be a normal aspect of a physician's career. The Special Committee believes that concepts and standards for physician reentry should be consistent with lifelong learning expectations for all physicians, which include reflective self-assessment, assessment of knowledge and skills, and performance in practice.

In formulating this report, the Special Committee reviewed existing reentry activities and programs of state member boards, sought guidance from published literature, and consulted with other advisors. The Special Committee identified key reentry issues, and has developed 12 Reentry Guidelines.

The goal of the Special Committee's Report and 12 Reentry Guidelines are to provide to the FSMB and its state member boards a framework of common standards and conceptual processes for physician and physician assistant reentry. The Special Committee has purposefully linked its recommendations to discussions and activities regarding Maintenance of Licensure (MOL), the American Board of Medical Specialties (ABMS) Maintenance of Certification (MOC), and the American Osteopathic Association and Bureau of Osteopathic Specialists' (AOA BOS) Osteopathic Continuous Certification (OCC).

The Special Committee recommends 12 Reentry Guidelines to the FSMB. These guidelines are organized as follows:

- Education and Communications Issues
- Determining Fitness to Reenter Practice
- Mentoring Practitioners Who Want to Reenter the Workforce
- Improving Regulation of Licensed Practitioners Who Are Clinically Inactive
- The Relationship between Licensure and Specialty Certification

For state member boards, implementation of the Special Committee's Reentry Guidelines may require review and revision of existing medical and osteopathic practice acts, consideration of staffing, costs and resource issues, modification of license application and renewal forms, integration of reentry with MOL activities, and initiation of proactive communications with prospective and current licensees and applicants.

## INTRODUCTION AND CHARGE

Freda Bush, MD, Immediate Past Chair of the FSMB Board of Directors, recently stated: “The question of how physicians reenter the practice of medicine after an extended absence for a significant period of time has always been important – and challenging – to SMBs. Ensuring physicians are qualified to reenter practice after a period of clinical inactivity is a complex process, which involves close coordination of education, testing, monitoring and regulation.”<sup>1</sup>

The Federation of State Medical Boards (FSMB) Special Committee on Reentry to Practice was convened in the late summer of 2010. The Committee was charged with issuing recommendations to the FSMB Board of Directors concerning physician and physician assistant reentry to the practice of medicine as outlined below.

1. Review and evaluate the recommendations relative to reentry in the Special Committee on Maintenance of Licensure as contained in its 2008 draft report;<sup>2</sup>
2. Review and evaluate the policies, procedures and other mechanisms currently used by state member boards to oversee physicians and physician assistants in reentering the active practice of medicine;
3. Review and evaluate the work to date on issues related to reentry to practice from medical professional organizations and other entities, including the AMA, AOA, AAP, et al;
4. Review and evaluate the FSMB’s recommendations related to Maintenance of Licensure (MOL) and its implementation and develop recommendations as to how MOL requirements can be aligned with reentry to practice requirements;
5. Establish and recommend guidelines that state member boards can utilize to determine the competence of physicians who have been out of clinical practice for a significant period of time for non-disciplinary reasons;
6. Provide guidance about the potential application of guidelines developed as part of #5, to disciplinary, impairment or retraining issues that may be associated with reentry.

Recognizing that physician reentry is becoming a common career trajectory and a normal part of a physician’s continuing practice of medicine, the goal of the Special Committee’s Report is to provide to the FSMB and its state member boards a framework of common standards and conceptual processes for physician and physician assistant reentry.

Reentry programs are consistent with lifelong learning expectations for physicians and there is some evidence that physicians who participated in a supportive, structured educational program were generally successful in achieving their goal of restoring licensure and returning to practice.<sup>3</sup>

Although reentry affects a broad spectrum of health care providers, the Special Committee’s intent is to make its recommendations useable for physicians and physician assistants. Implementation of the Special Committee’s recommendations should result in a reentry process that is appropriately comprehensive, but practical and flexible enough to address a variety of situations and specialties. The Special Committee also specified that its report should provide common standards and conceptual processes for state member boards to implement the recommendations, and not necessarily be a specific “tool box” at this point. They agreed that important outcomes would be to fulfill SMBs’ mission of ensuring public safety, an increase in public confidence in physicians and their licensing boards,

enhanced communications between SMBs and physicians about the implications of what taking a leave from practice means and increased awareness of how physicians should prepare for such an event.

The Special Committee developed a description of desired outcomes for this project and the audience, scope and organization of the report. This information is contained in Attachment A. A glossary is included in Attachment B. Attachment C provides a listing of barriers to reentry as developed by The Physician Reentry into the Workforce Project of the American Academy of Pediatrics. Attachment D is a summary of the FSMB policy on Maintenance of Licensure, which is referred to frequently in this report. Attachment E provides a number of resources from state member boards that are intended to provide practical assistance on reentry. Attachment F provides references for additional literature on reentry.

## **NEED FOR REENTRY GUIDELINES FOR STATE MEMBER BOARDS**

It is reported that a growing number of physicians are making the decision to take leave from the clinical practice of medicine, with many seeking to return at some future point<sup>4</sup>. Physicians may take a break from practice due to family responsibilities or they may decide to temporarily focus on research or administrative careers not involving the everyday practice of medicine. Other reasons physicians take time off from clinical practice include birth of a child, child care, caring for an ill family member, personal health, military service, humanitarian leave, and change in career path and career dissatisfaction.<sup>5</sup>

Regardless of the reasons for an interruption in practice, it is critical for SMBs to address reentry for the following reasons:

- To advance patient safety and quality of care;
- For SMBs to provide a standardized process for physicians and physician assistants, who may take a temporary leave from practice, to demonstrate their competence prior to reentering practice;
- For physicians who leave practice and do not reenter, there is:
  - A loss of physician contributions to the health care delivery system;
  - A worsening of the current access problems, especially in underserved areas;
  - The forfeiture of the investment in medical education and specialty/subspecialty training;
- Reentry to practice may offer an additional and more cost-effective means of addressing the anticipated national physician shortage and/or responding to national or local emergencies, such as natural disasters.

Several SMBs have already addressed reentry in response to the above points in order to assure citizens of their respective states that physicians who leave clinical practice are qualified to return. There is research that indicates that physicians who have been out of practice a certain number of years lose their skills.<sup>6</sup> With the emphasis on outcomes measurement in health care reform, it is anticipated that there will be increased demand for programs of quality assessment for those in practice as well as those reentering it.

SMBs are also concerned that Maintenance of Licensure (MOL) requirements<sup>7, 8</sup> and the ongoing rollout of American Board of Medical Specialties Maintenance of Certification (ABMS MOC) and the American Osteopathic Association Bureau of Osteopathic Specialists (AOA BOS) Osteopathic Continuous Certification (OCC) requirements may uncover a significant number of physicians who are not in active

clinical practice. The same activities that physicians may need to meet MOL and specialty board certification requirements should also be used as part of a reentry process. SMBs are anticipating that there will be a link between MOL/MOC/OCC and Performance in Practice requirements, and reentry guidelines are needed to avoid unnecessary duplication.

Finally, there are a host of barriers for physicians who want to reenter practice (see Attachment C for a listing developed by the American Academy of Pediatrics Physician Reentry Project). The FSMB, working with its state member boards, can develop a more unified system to help address and reduce those barriers to reentry.

There are concerns that Maintenance of Licensure and certification requirements will identify a significant number of physicians who will need reentry activities. There is also anecdotal evidence that the problem is increasing in part because of economic and demographic changes among physicians. It appears that there are increasing numbers of retired physicians who desire to return to practice to augment their incomes during the current economic recession.<sup>9</sup> With women comprising a larger percentage of the physician workforce, they often, although not exclusively, may take on responsibilities of childbirth, childcare, and caring for an ill or elderly family member.<sup>10</sup>

## KEY REENTRY ISSUES

Physician reentry into clinical practice can be defined as returning to professional activity/clinical practice for which one has been trained, certified or licensed after an extended period.<sup>11</sup> Reentry is an issue that cuts across genders and specialties. However, anecdotal evidence indicates that reentry into the workforce affects women more often than men.<sup>12</sup> Although there is paucity of data on this complex topic, many agree that it is an issue that is gaining prominence,<sup>13</sup> and is crucial to continuing public safety.

The Special Committee identified several key issues to be addressed during its work. The following list is neither exhaustive nor in an order of priority.

- **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 a 15-year-old FSMB policy, but further information is needed. In the absence of data, the Committee recognizes the need for flexibility when applying the two-years-away-from-practice timeframe to an individual practitioner, as there is great variability in specialty, type of practice, etc.
- **Data Needs:** More data are needed to know how many physicians are impacted by reentry issues. Information about how many physicians are clinically inactive but maintain an active license to practice is needed. The number of physicians who have been out of practice and have sought or are currently seeking reentry is needed. Although data are lacking, the Committee believes that anecdotal evidence speaks to the need for reentry interventions and that a growing number of physicians will need reentry tools and programs.
- **SMB Data Collection:** There is an urgent need for SMBs to add questions to their license renewal applications in order to help determine the status of physicians and the magnitude of the reentry problem.

- **Congruence with Maintenance of Licensure and Maintenance of Certification:** SMBs need to ensure that licensees and applicants are ready to reenter after a period of inactivity. However, as SMBs design or redesign their reentry programs, they should allow activities that physicians may need to meet MOL and specialty board certification requirements to satisfy the reentry process.
- **Barriers to Reentry:** There are difficulties associated with identifying entities that provide reentry services to physicians. Cost, geographic considerations, eligibility requirements, licensure, malpractice issues and lack of uniformity among alternatives available to physicians seeking reentry are problematic.
- **Mentors of Reentry Physicians:** The availability of physician mentors and the processes of vetting their skills, paying them for their work, and defining the types of tools they should use in assisting those physicians who are on a reentry path are considerations that need to be addressed.
- **Role of Academic Medical Centers (AMCs) and Community Hospital Training Centers:** Because they already have the facilities and resources, AMCs could play multiple roles in the reentry process. They could provide a complete reentry package from initial assessment of the reentry physician to his or her final evaluation of competence and performance in practice. Academic Medical Centers could provide selected services on an as-needed basis such as assessment testing, focused practiced based learning, procedure labs and providing and vetting mentors. Potential incentives to stimulate AMC involvement in reentry include research opportunities and generation of revenue.
- **Resources for Funding:** There is a need for funding to help cover the costs of physician reentry. Federal, state and local funding driven by physician shortages may become a funding source. Potential employers, including community hospitals and large group practices, may be willing to offset individual physician reentry costs in exchange for later service. There is a challenge to creatively find new funding, both nationally and locally, and promote its availability.
- **Medical Liability Insurance:** Better understanding is needed about how malpractice coverage works when physicians leave and when they reenter practice. It would also be helpful to know how coverage for mentoring physicians is handled.
- **Maintaining Licensure if Not in Active Clinical Practice:** SMBs are facing the question of whether physicians who are not in active clinical practice should be allowed to maintain an active license. 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 recognize administrative medicine as a distinct area of practice and issue full and unrestricted licenses to administrative physicians with the expectation that administrative physicians, like all other licensees/applicants, appropriately limit their practice to areas where they are competent.
- **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. For example, an obstetrician/gynecologist may wish to practice family medicine. Another example is when a physician seeks to modify his or her primary area of practice, such as when an

obstetrician/gynecologist seeks to only practice gynecology. It is uncertain how much, if any, additional training might be needed for these types of physicians.

- **Simulation:** Simulations will play an important role in the future because they replicate cognitive and procedural skills and simulate team interaction. How can reentry activities take advantage of simulation centers and also pay for the services these centers might provide?

## INPUT FROM ADVISORS

As part of its work, the Committee invited several professionals experienced in reentry to help inform its opinions and recommendations via two webinars. These presenters, which included representatives from previously or currently active reentry programs, had firsthand experience with physician reentry programs and were willing to discuss their experiences. The Committee would like to thank: Robin Wooton, Executive Director, Society for Simulation in Health Care (SSH); Barry Manuel, MD, Associate Dean, Professor of Surgery, Boston University School of Medicine; Elizabeth J. Korinek, MPH, Board Member, Coalition for Physician Enhancement (CPE); and Joann Baumer, MD, John Peter Smith Hospital in Ft. Worth, Texas.

The participants discussed several issues including costs, effectiveness and need for reentry programs. Some specific considerations involved:

**Costs:** It appears that, depending on design, costs for participating in and completing a formal reentry program can range from \$5,000-\$20,000 per individual participant. For those who have been ill, taken family medical leave, or for those in primary care specialties, limited funds can make program costs especially prohibitive.

**Need for Programs:** It appears that currently the number of participants is relatively small. For example, approximately 30 physicians are participating in a three-year period at one program and approximately 60 are completing another six-month university program.

**Program Completion:** It appears that most physicians who begin the programs complete them successfully, although one program found through prescreening that 20-30% were judged not to have the capacity to complete the program.

**Programs Tailored to Individuals:** All of the presenters agreed that it was desirable to have flexible programs that addressed the tremendous variety of individual needs.

**Two-Year Minimum:** It was agreed that there is a need for a commonly accepted “out of practice” timeframe for physician reentry.

## ROLE OF STATE MEMBER BOARDS IN REENTRY

The Special Committee recognizes that several state member boards have strong policy and significant experience with the reentry process. The North Carolina Medical Board, for example, has supervised the reentry of approximately 60 physicians and 40 physician assistants. The Special Committee noted that Oregon, Massachusetts, and others have reentry rules (see Attachment E for examples). Based on

this experience, there appear to be a number of roles that state member boards can play in the process. For example, state member boards may:

- Develop a policy and provide advice to those desiring to reenter.
- Proactively identify those who are not complying with MOC or MOL requirements and inquire about their practice status and advise them of how to reenter.
- Notify all applicants/licensees about what they should do in advance of taking a leave from the practice of medicine in order to avoid future reentry problems.
- Directly supervise the reentry process using Board staff, while others will rely on programs in place for this purpose or academic medical centers
- Cooperate, perhaps on a regional basis, to best serve licensees/applicants and make best use of limited resources.
- Facilitate or support programs at academic medical centers in their state or region.

Recently, Nebraska enacted a law to provide for reentry licenses under its Medicine and Surgery Practice Act. Upon recommendation of the state board, a physician who has not been actively practicing medicine for the two-year period immediately preceding, or who has not otherwise maintained continued competency during such period as determined by the board, may qualify for a reentry license, which can then convert to a regular license after completion of assessment and supervised practice.

### **SUGGESTED REENTRY GUIDELINES\***

The following 12 guidelines are intended to help SMBs facilitate a physician's reentry to practice while simultaneously ensuring the public is protected. Building on the FSMB's work in Maintenance of Licensure (MOL), the Special Committee believes that for individual physicians the reentry process should segue into MOL. Whenever possible, the three MOL components (Reflective Self-assessment, Assessment of Knowledge and Skills, and Performance in Practice) have been included as part of the reentry process.

While some of the guidelines contained herein may be appropriate for physicians whose absence is due to disciplinary or impairment reasons, the guidelines are primarily intended to address situations where a physician has taken a voluntary leave of absence. For purposes of this report, the recommendations apply to both physicians and physician assistants.

The Special Committee discussed the issue of impaired physicians and how the following guidelines might affect them and their SMBs. After a review of the FSMB Policy on Physician Impairment, which was adopted by the FSMB as policy in 2011, it was decided that these guidelines do not conflict with the FSMB policy and, in fact, enhance it.<sup>14</sup> It is suggested that SMBs use these guidelines on Physician Reentry to augment their programs and to convey the importance of a reentry plan to the physicians participating in an Impaired Physician Program.

*\*This section is adapted from the draft final report of the Special Committee on Maintenance of Licensure (2008).*

## **Education and Communication Issues**

### **Guideline 1: Proactive Communications**

To help prepare licensees/applicants who either are thinking about taking a leave of absence or are considering returning to clinical practice, SMBs should proactively educate licensees/applicants about the issues associated with reentering clinical practice (e.g., continued participation in CME activities while out of practice, unintended consequences of taking a leave of absence such as impact on malpractice costs and future employment).<sup>15</sup> For example, SMBs could develop written guidance on issues like the importance of engaging in clinical practice, if even on a limited, part-time basis, or seeking counsel from their insurance carriers prior to withdrawal from practice and when they are ready to reenter practice. They might also suggest that the licensee/applicant consult the Inventory created by the Physician Reentry to the Workforce Project ([www.physicianreentry.org](http://www.physicianreentry.org)).<sup>16</sup> State member 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.

### **Guideline 2: Flexibility**

The medical community will have to determine how to make the system flexible enough to accommodate reentering practitioners whose personal lives or professional goals interfere with the ability to remain clinically active. All entities that depend on physicians to provide clinical care should be encouraged to accommodate individuals who are interested in returning to clinical practice but who may need flexible or part-time scheduling. A recent study concluded that the lack of opportunities for part-time work and flexible scheduling may preclude some who otherwise would reenter practice from returning to practice.<sup>17</sup> This systemic issue is difficult for SMBs to address, but it remains a significant issue.

## **Determining Fitness to Reenter Practice**

It is the responsibility of SMBs to determine whether a licensee/applicant who has had an interruption in practice should demonstrate whether he or she is competent to return to practice. Of the 30 boards that have a reentry policy, a majority use a two-year continuous interruption in practice as an indicator for the need for a reentry activity, although requirements range from one to five years.<sup>18</sup> The FSMB recommends that for licensure by endorsement, SMBs should adopt a flexible approach based on an applicant's individual needs, and guidelines established by the licensee/applicant specialty society or specialty board. SMBs may be guided by the concept that those who have not been in active practice for the previous 24-month period may be required to demonstrate their continued competence. Despite SMB requirements and FSMB recommendations, little research is available to inform discussions about how time away from clinical practice impacts competence.

### **Guideline 3: 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 extended leave should be considered on a case-by-case basis. 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

length of time out of practice, what the practitioner has done while away from practice, the licensee/applicant's prior and current or intended area of specialization, prior disciplinary history, hospital privilege reports, and the licensee/applicant's participation in continuing medical education and/or volunteer activities during the time out of practice. 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 MOC, OCC, National Commission on Certification of Physician Assistants (NCCPA) certification maintenance processes and MOL activities if available.

#### **Guideline 4: 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 his or her medical education and training. For example, documented evidence might include CME certificates and verification of volunteer activities.

The Special Committee distinguishes between the need for reentry and the need for retraining. A physician returning to a scope or area of practice in which he/ she is previously trained or certified, or in which he/ she previously had an extensive work history may need reentry. A physician returning to clinical work in an area or scope of practice in which he or she has NOT previously trained or certified or in which he/ she has NOT had an extensive work history needs retraining and, for the purposes of this report, is not considered a reentry physician. Because the licensee/applicant's intended scope of practice may not be the same as the specialty in which he/ she is trained or board certified, 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.

#### **Guideline 5: Reentry Plan**

Licensees/applicants who have been clinically inactive should become involved in a reentry plan approved by the state member board before reentering the workforce. The reentry plan should include three fundamental components: reflective self-assessment by the licensee/applicant, assessment of the licensee/applicant's knowledge and skills, and the licensee/applicant's performance in practice as defined by the FSMB requirements for Maintenance of Licensure.<sup>19</sup>

State member boards should approve the elements and scope of the reentry plan prior to its initiation. Subsequently, the licensee/applicant should be required to present the outcomes of the reentry plan to the state member board.

If the licensee/applicant has not previously implemented a reentry plan, then SMBs may be authorized as needed to use non-punitive, time-limited license mechanisms to return a practitioner's license to active, unrestricted status. Such a mechanism permits 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.

### **5a: Reflective Self-assessment**

Reentry documentation should reflect the licensee/applicant's participation in assessment and/or self-reflection activities with subsequent successful completion of educational activities tailored to address weaknesses or deficiencies identified through the assessment. These activities should be congruent with Component One of the FSMB MOL Framework. (See Attachment D) Continuing medical education activities presented by the licensee/applicant in support of his/ her competence should be relevant to the area of practice in which the licensee/applicant intends to engage and should be certified by an agency acceptable to the state member board.

### **5b: Assessment of Knowledge and Skills**

Congruent with MOL Component Two: Assessment of Knowledge and Skills, state member boards should require licensees to undertake objective knowledge and skills assessments to identify learning opportunities and guide improvement activities.

SMBs should provide guidance about the appropriate content of a reentry plan. For example, SMBs could ask licensees/applicants to provide the results of their self-assessment, the processes used to assess knowledge and skills, and the means by which performance in practice was evaluated. Other appropriate content should include the qualifications of the mentoring physician, information from the mentor about the licensee/applicant's clinical duties and responsibilities, location of the practice, approximate number of hours worked, patient volume and acuity, procedures done, results of chart audits, method of mentoring, and frequency of direct observation.

Documentation of such activities should be required. For example, mentors should be sufficiently vetted to participate with the licensees/applicants' process of assessment. There are also recognized assessment programs that are available and could be an option for meeting this requirement.

### **5c: Performance in Practice:**

Consistent with MOL Component Three: Performance in Practice, licensees/applicants should also be required to provide documentation showing their satisfactory performance in practice as part of a reentry plan. Qualifying activities could include a variety of methods that incorporate reference data to assess physician performance in practice as a guide to improvement. Potential resources that may be used to specifically address the component include standardized testing (e.g., SPEX, COMVEX, other), practice mentors, chart audits, "mini-residencies," individualized, tailored continuing medical education and evaluation by a formal assessment program, or other equivalent activities.

### **Guideline 6: SMB Collaborative Relationships**

State member boards should foster collaborative relationships with academic institutions, community hospital training centers and specialty societies within their jurisdictions to develop assessment, educational and other interventions and resources for the various types of practices. The National Board of Osteopathic Medical Examiners, the National Board of Medical Examiners, the American Board of Medical Specialties, and the American Osteopathic Association Bureau of Osteopathic Specialties may likewise serve in a supportive role to state member boards in this regard. These institutions and organizations may have readily adaptable programs or simulation centers that meet the individual needs of reentering physicians.

## **Mentoring for Practitioners Who Want to Reenter the Workforce**

### **Guideline 7: Board-approved Practice Mentors**

Practice mentors may be selected by either the state member board or the licensee/applicant, but in all cases should be approved by the state member board. At a minimum, the practice mentor should be ABMS or AOA board certified and practice in the same clinical area as the licensee/applicant seeking reentry.

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

The practice mentor should be required to demonstrate to the board's satisfaction that he/ she has the capacity to serve as a practice mentor, for example, sufficient time for mentoring, lack of disciplinary history, proof of an active, unrestricted medical license, and/or demonstration of a prescribed number of years in clinical practice. The practice mentor may be permitted to receive financial compensation or incentives for work associated with practice mentoring. Potential sources of bias should be identified and in some cases may disqualify a potential mentor from acting in that capacity.

State member boards should work with the state medical and osteopathic societies and associations and the medical education community to identify and increase the pool of potential practice mentors. For example, to protect the pool of mentors, some SMBs have made them agents of the board.

### **Guideline 8: Transition to a Full Unrestricted License**

Physicians and physician assistants who have gone through a reentry process and receive a full, unrestricted license should then be subject to the same rules and regulations as other licensees.

## **Improving Regulation of Licensed Practitioners Who Are Clinically Inactive**

State member boards should implement the following mechanisms to improve regulation of licensed practitioners who are clinically inactive but may return to clinical practice in the future.

### **Guideline 9: Identifying Clinically Inactive Licensees**

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

The report of the FSMB Workgroup to Define Minimal Data Set is expected to provide additional recommendations regarding a minimal physician demographic data set that state member boards should collect as part of the licensure process. In addition, the report of the FSMB Maintenance of Licensure Workgroup on Non-Clinical Physicians is expected to provide recommendations regarding how non-clinically active physicians may participate in a state member board's MOL program and how participation in such a program should be evaluated at the time of reentry to clinical practice.

#### **Guideline 10: Licensure Status**

Licensees who are clinically inactive should be allowed to maintain their licensure status as long as they pay the required fees and complete any required continuing medical education or other requirements as set forth by the board. Upon a licensee's decision to return to clinical practice, he or she should be required to participate in a reentry process.

#### **Guideline 11: Consistency of Reentry across Jurisdictions**

State member boards should be consistent in the creation and execution of reentry processes. 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 SMB, these guidelines are designed to be flexible to meet local considerations. At the same time, physicians may 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 should coordinate the implementation of these guidelines so there is as much consistency as possible.

#### **Relationship between Licensure and Specialty Certification**

A physician's ability to maintain specialty board certification during a leave of absence will depend on whether the physician has voluntarily allowed his or her license to lapse. The 24 boards of the American Board of Medical Specialties (ABMS) have implemented Maintenance of Certification (MOC) programs, which require, in part, the physician's ability to demonstrate good professional standing by virtue of having a full and unrestricted license. In addition, the American Osteopathic Association Bureau of Osteopathic Specialists (AOA BOS) is implementing an Osteopathic Continuous Certification (OCC) program, which also requires, in part, demonstration of a full and unrestricted license.

#### **Guideline 12: Maintenance of Specialty Certification**

In situations where a licensed, board certified physician is returning to clinical practice, state member boards should make every effort to ensure that any conditions for the physician's reentry to practice do not hinder the physician's ability to maintain specialty certification.

### **IMPLICATIONS FOR STATE MEMBER BOARDS AND THE ROLE OF FSMB**

The Special Committee on Reentry to Practice discussed possible implications of reentry on SMBs and the role of the FSMB in implementing the Special Committee's recommendations. For state member

boards, there will be a need to review and perhaps revise their medical practice acts, to consider staffing, costs and resource issues, to modify license application and renewal forms, to integrate reentry with MOL activities and to initiate proactive communications with prospective and current licensees/applicants.

To assist SMBs with implementing reentry requirements, FSMB should consider the following suggestions:

- FSMB should develop a uniform set of questions for SMBs to add to their license renewal application.
- Once guidelines are adopted as policy, FSMB should offer advice and consultation to their member boards.
- FSMB should commit to reviewing its reentry recommendations and policy every three to five years to ensure it remains current.
- FSMB could develop standards for language, forms and checklists to assist in implementation. For example, FSMB could provide sample guidance on issues like the importance of engaging in clinical practice, if even on a limited and part-time basis, or seeking counsel from their insurance carriers prior to withdrawal from practice.
- FSMB can help share best practices, information and resources across states through conferences, the FSMB Annual Meeting, publications and web-based reporting tools.

## **CONCLUSION AND NEXT STEPS**

Widespread and well-defined physician reentry processes will probably not be fully realized nationwide for several years. During that time, the Special Committee recommends that FSMB launch a systematic effort to encourage states to share with each other what is working and what may need improvement in order to define best practices. Most immediately, there is a need to understand the magnitude of the problem.

As indicated in Guideline 9, state member boards should require licensees/applicants to report information about their practice as part of the license renewal or registration process. When these data are collected nationwide and reported, there will be a much stronger understanding of the opportunity to increase the physician and physician assistant workforce.

Secondarily, there is a significant need to develop an evidence base for reentry. Research is needed about the type and degree of assessment that is required to determine educational needs. Another question deserving study is the effectiveness of various types of reentry programs.

Finally, the short and long term results of reentry programs must be evaluated. Although there is evidence from the existing reentry programs that most physicians who begin a reentry program complete it successfully, more systematic research needs to be undertaken, especially regarding the two-year time frame precedent. Also, longer term follow up studies will be necessary to determine if those completing program make a successful transition to practice and what, if any, obstacles they may encounter.

## **SPECIAL COMMITTEE DESIRED OUTCOMES**

The Special Committee agreed that its work should be focused on the following desired outcomes:

- The overall goal should be to establish physician reentry as a common career trajectory with an expectation that it is a normal part of a physician’s continuing practice of medicine.
- Although reentry affects a broad spectrum of health care providers, the Special Committee’s intent is to make its recommendations useable for physicians and physician assistants; implementation of the Special Committee’s recommendations should result in a reentry process that is rigorous, but practical and flexible enough to address a variety of situations and specialties.
- The report should provide common standards and conceptual processes for state member boards to implement the recommendations, and not necessarily be a specific “tool box” at this point.
- Recommendations from the Special Committee should increase public confidence in physicians and their licensing boards; the ideal would be for the recommendations to be linked to the enhancement of patient outcomes.
- An important outcome will be enhanced communications between SMBs and physicians about the implications of what taking a leave from practice means and increased awareness of how physicians should prepare for such an event.
- The Special Committee believes involvement of academic medical centers in reentry activities, including focused research on this topic, is highly desirable.
- The report should explicitly link reentry with Maintenance of Licensure (MOL), ABMS Maintenance of Certification (MOC), and AOA BOS Osteopathic Continuous Certification (OCC).

## **THE AUDIENCE, SCOPE AND ORGANIZATION OF THE SPECIAL COMMITTEE REPORT**

The Special Committee discussed the nature of the report and provided the following guidance.

- The primary audience for the report will be state member boards, with the understanding that the report could be useful and easily adapted to the following secondary audiences of individuals and groups: physicians and physician assistants, students, residents, specialty organizations, hospital credentialing groups, national and state legislators and regulators, and the public.
- It will be important to establish the rationale for the work; the audience must be able to clearly understand why guidelines or pathways for state member boards are needed.
- The report should be of journal quality, media-worthy and also be clear and relevant to SMBs and their licensees/applicants, perhaps including diagrams and algorithms; perhaps a 10-page document with additional appendices.
- Clear definitions of what is meant by reentry, active practice and inactive practice, for example, should be provided in the glossary.

- The tone of the report should be positive and reinforce the concept that reentry is an accessible and professionally rewarding process.
- The report will focus on undifferentiated licenses and not address administrative licenses, which should be deferred until the FSMB Maintenance of Licensure Initiative progresses.
- The Committee also discussed whether its recommendations should address non-physician clinicians beyond physician assistants and decided that the recommendations will be available to other groups that could chose what to adopt for their use.

## GLOSSARY

The following definitions were adapted from the AAP Physician Reentry into the Workforce Project, the AMA, the AOA, the American Board of Medical Specialties, and the FSMB Special Committee report on Maintenance of Licensure.

**AMA Definition of Physician Reentry:** 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; distinct from remediation or retraining.

**AAP Definition of Physician Reentry:** Returning to professional activity/clinical practice, for which one has been trained, certified or licensed after an extended period.

**Clinically Active Practice:** Clinically active status is defined as any amount of direct and/or consultative patient care that has been provided in the preceding 24 months. STANDARDS FOR ABMS MOC® (PARTS 1-4) PROGRAM, Approved March 16, 2009

**Clinically Inactive Practice:** No direct and/or consultative patient care that has been provided in the past 24 months. STANDARDS FOR ABMS MOC® (PARTS 1-4) PROGRAM, Approved March 16, 2009

**Comprehensive Osteopathic Medical Variable-Purpose Examination (COMVEX):** The evaluative instrument offered by the National Board of Osteopathic Medical Examiners for osteopathic physicians who need to demonstrate application of clinical knowledge for the practice of osteopathic medicine.

**Education:** The process whereby deficiencies in physician performance identified through an assessment system are corrected.

**Impaired Physician:** A physician who is unable to fulfill personal or professional responsibility because of psychiatric illness, alcoholism, or drug dependency.

**Maintenance of Certification:** In 2000, the 24 member boards of the American Board of Medical Specialties (ABMS) agreed to evolve their recertification programs to one of continuous professional development – ABMS Maintenance of Certification® (ABMS MOC®). ABMS MOC assures that the physician is committed to lifelong learning and competency in a specialty and/or subspecialty by requiring ongoing measurement of six core competencies adopted by ABMS and ACGME in 1999.

**Maintenance of Licensure:** Maintenance of Licensure is a system of continuous professional development that requires all licensed physicians to demonstrate, as a condition of license renewal, their involvement in lifelong learning that is objective, relevant to practice and improves performance over time.

**Mentoring:** a dynamic, reciprocal relationship in a work environment between two individuals where, often but not always, one is an advanced career incumbent and the other is a less experienced person. The relationship is aimed at fostering the development of the less experienced person. (Baucher H. Mentoring Clinical Researchers. Archives of Diseases of Children. 2002;86; 82-84.)

**Osteopathic Continuous Certification:** The American Osteopathic Association's Bureau of Osteopathic Specialists (AOA BOS) has mandated that each specialty certifying board implement "Osteopathic Continuous Certification" (OCC). OCC will serve as a way for board certified DOs can maintain currency and demonstrate competency in their specialty area. The American Osteopathic Association's seven core competencies are: 1) medical knowledge, 2) patient care, 3) practice-based learning and improvement, 4) interpersonal and communication skills, 5) professionalism, 6) systems-based practice, and 7) osteopathic philosophy and osteopathic manipulative medicine.

**Physician Assistant Certification Maintenance Process:** The National Commission on Certification of Physician Assistants is expanding its long-standing requirements of continuing medical education and regular retesting to include new self-assessment activities and performance improvement activities.

**Physician Reentry Program:** Structured curriculum and clinical experience which prepared physicians to return to clinical practice following an extended period of clinical inactivity.

**Physician Reentry Program System:** Provides a way of organizing and planning physician reentry programs.

**Physician Retraining:** The process of updating one's skill or learning the necessary skills to move into a new clinical area.

**State Member Boards:** State medical and osteopathic licensing boards that oversee the activities of the physicians licensed in the states, District of Columbia and U.S. Territories, assuring that a high standard of practice by the physicians is maintained. (Adapted from McGraw-Hill Concise Dictionary of Modern Medicine. © 2002 by The McGraw-Hill Companies, Inc.)

**REENTRY BARRIERS**  
**(from the Physician Reentry into the Workforce Project**  
**of the American Academy of Pediatrics)**

The Physician Reentry into the Workforce Project maintains that decisions to leave and then reenter the workforce should be regarded as part of a physician's career trajectory, and not as an unusual event. Physicians who are considering leaving clinical practice, as well as those who are planning to reenter, should understand and acknowledge that there can be barriers to this process. Not all physicians will encounter all or even most of these barriers on the following list, but it is wise to be prepared.

- Physician/Practitioner Factors:

- Lack of confidence and/or psychological concerns;
- Lack of knowledge and skills, both clinical and documentation skills (i.e., EMR experience);
- Lack of experience and comfort with other technological advances (i.e., internet searches, PDA use, etc.);
- Lack of knowledge of requirements, sometimes leading to decisions that cause difficulty in returning (such as allowing a license to lapse or become inactive);
- Failure to maintain knowledge in their clinical specialty because they do not anticipate a return to medicine;
- “Unconscious incompetence” – even though the practitioner may have tried to prepare, s/he may be unaware of or unable to anticipate all areas in which s/he needs to update; inability to self-assess educational needs relative to the needs of the prospective practice setting; personal feelings of adequacy or ability to practice medicine as needed;
- Pride: difficulty admitting that one is in need of further training;
- Lack of time to address the educational needs; and inability to plan for oneself how to address the needs;
- Difficulty determining when the educational gap is sufficiently addressed.

- Licensure and Licensing Board Factors:

- Failure to educate practitioners who allow their license to lapse of these requirements and potential consequences;
- Requirements that may be vague, arbitrary, and may have changed over time (or may in the future);
- Requirements that differ in vigor from state to state;
- Limited options given by which to demonstrate competence for any given state;
- Limited means available by which to demonstrate competence;
- Lack of understanding whether the options to demonstrate competence actually do so; lack of understanding of what can be used as a proxy for “competence”;
  - Often the criteria used is hands-on patient care in the U.S. (and the only criteria accepted by boards);
  - If criteria exist (such as the “two-year rules”) they often do not

differentiate between specialties. For example, perhaps “hands-on” care is more relevant for maintaining “competence” in surgical and procedural based specialties, and the critical time out period should be different for procedural and non-procedural specialties;

- Licensing organizations do not usually risk-stratify practitioners in deciding how a physician should prove competency after a time away (based on factors such as whether the practitioner is/was ever board certified, or whether the physician has required to recertify periodically, and has done so).

- Hospital and Other Privileging Bodies:

- Discomfort with and/or lack of willingness to allow privileges to a physician who has not been in recent clinical practice;
- Significant variations in this comfort level between hospitals (even for the same specialty);
- Varying ability to provide proctoring or work with physicians in a staged re-entry process (i.e., gradually lessening levels of supervision);
- Hesitance of managed care organizations and medical insurance companies to accept a re-entering physician onto their provider panel.

- Liability Coverage Factors:

- Discomfort with and/or lack of willingness to provide liability coverage to a physician who has not been in recent clinical practice;
- Significant variations in this comfort level between insurers and from individual to individual.

- Prospective Employer Factors:

- As with all the other levels, lack of understanding of how to judge competence of a clinician who does not have recent clinical experience;
- Limited availability of flexible work options;
- Lack of support from the institution and colleagues for those integrating back into the workplace.

- Reentry Program Factors:

- Discomfort with and lack of practicality in providing a “certificate of competence”;
- Variability in what each program can offer to the practitioner and offer to the prospective board/hospital/malpractice insurer, etc.
- Limited availability of sites where re-entry programs can provide hands on clinical experiences for physicians because of the above factors;
- Cost of and distance to established programs; need for convenient and affordable programs;
- Need for flexible programs;

- Lack of standardization of how these evaluations are done and/or reentry process is conducted.
- Home and Family Barriers:
  - Ongoing needs such as childcare and needs of other family/household members;
- Multi-level Factors:
  - Multiple different layers of regulating and certifying bodies with different criteria for demonstration of aptitude and proficiency (which may or may not equate to competence), all of which the practitioner must fulfill; for example, requirements to maintain specialty board certification are not considered adequate demonstration of competence by boards and licensing authorities;
  - Unclear who is/should be the decision-maker in such matters;
  - Need for counseling to provide direction regarding the kind of learning and training needed.

For more information on The Physician Reentry into the Workforce Project visit [www.physicianreentry.org](http://www.physicianreentry.org)

*Physician Reentry into the Workforce Project. Issue Brief: Reentry Barriers. Elk Grove Village, Ill. American Academy of Pediatrics; 2010.*

**FSMB MAINTENANCE OF LICENSURE FRAMEWORK**

As a condition of license renewal, physicians should provide evidence of participating in a program of professional development and lifelong learning that is based on the general competencies model:

- medical knowledge
- patient care
- interpersonal and communication skills
- practice based learning
- professionalism
- systems based practice

The following requirements reflect the three major components of what is known about effective lifelong learning in medicine.

1. Reflective Self Assessment (What improvements can I make?)

Physicians must participate in an ongoing process of reflective self-evaluation, self-assessment and practice assessment, with subsequent successful completion of appropriate educational or improvement activities.

2. Assessment of Knowledge and Skills (What do I need to know and be able to do?)

Physicians must demonstrate the knowledge, skills and abilities necessary to provide safe, effective patient care within the framework of the six general competencies as they apply to their individual practice.

3. Performance in Practice (How am I doing?)

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.

**STATE MEMBER BOARD RESOURCES**

**Oregon Administrative Rules on Reentry for Physician Assistants (p. 27)**

**Oregon Administrative Rules on Reentry for Physicians (p. 28)**

**North Carolina Rule on Reentry to Practice (p. 30)**

**Nebraska Reentry License (p. 33)**

A detailed overview of state board requirements for reentry is also available in the *2012 State Medical Licensure Requirements and Statistics* book published by the American Medical Association. The book includes data such as number and percent of boards that currently have a reentry policy, the average length of time out of practice after which boards require a reentering physician to complete a reentry program, and a table of physician reentry regulations by board.

**OREGON MEDICAL BOARD PROPOSED RULE ON REENTRY FOR PHYSICIAN ASSISTANTS  
CHAPTER 847, DIVISION 050 – OREGON MEDICAL BOARD**

**PROPOSED RULES CHANGES - FIRST REVIEW – JULY 2011**

**Proposed rule amendment establishes requirements for re-entry to practice after ceasing practice for more than one year and contains general language and grammar housekeeping.**

**847-050-0043**

Inactive Registration and Re-Entry to Practice

(1) Any physician assistant licensed in this state who changes location to some other state or country, or who is not in a current supervisory relationship with a licensed physician for 6 months or more, will be listed by the Board as inactive.

(2) If the physician assistant wishes to resume active status to practice in Oregon, the physician assistant must submit the Affidavit of Reactivation and processing fee, satisfactorily complete the reactivation process and be approved by the Board before beginning active practice in Oregon.

(3) The Board may deny active registration if it judges the conduct of the physician assistant during the period of inactive registration to be such that the physician assistant would have been denied a license if applying for an initial license

(4) If a physician assistant applicant has ceased practice for a period of 12 or more consecutive months immediately preceding the application for licensure or reactivation, the applicant may be required to do one or more of the following:

(a) Obtain certification or re-certification by the National Commission on the Certification of Physician Assistants (N.C.C.P.A.);

(b) Provide documentation of current N.C.C.P.A. certification;

(c) Complete 30 hours of Category I continuing medical education acceptable to the Board for every year the applicant has ceased practice;

(d) Agree to increased chart reviews upon re-entry to practice.

(5) The physician assistant applicant who has ceased practice for a period of 24 or more consecutive months may be required to complete a re-entry plan to the satisfaction of the Board. The Board must review and approve a re-entry plan prior to the applicant beginning the re-entry plan. Depending on the amount of time out of practice, the re-entry plan may contain one or more of the requirements listed in section (4) of this rule and such additional requirements as determined by the Board.

Stat. Auth.: ORS 677.265

Stats. Implemented: ORS 677.512

**OREGON PROPOSED ADMINISTRATIVE RULES FOR PHYSICIANS  
CHAPTER 847, DIVISION 020 – OREGON MEDICAL BOARD**

**FIRST REVIEW RULE ADOPTION – OCTOBER 2011**

**The amendment includes the new Osteopathic school opening in Oregon and clarifies the standards for re-entry to practice.**

**847-020-0183**

Re-Entry to Practice – SPEX or COMVEX Examination, Re-Entry Plan and Personal Interview

If an applicant has ceased the practice of medicine for a period of 12 or more consecutive months immediately preceding the application for licensure or reactivation, the applicant may be required to demonstrate clinical competency.

(1) The applicant who has ceased the practice of medicine for a period of 12 or more consecutive months may be required to pass the Special Purpose Examination (SPEX) or Comprehensive Osteopathic Medical Variable-Purpose Examination (COMVEX). This requirement may be waived if the applicant has done one or more of the following:

(a) The applicant has received a current appointment as Professor or Associate Professor at the Oregon Health and Science University or the Western University of Health Sciences College of Osteopathic Medicine of the Pacific; or

(b) The applicant has within ten years of filing an application with the Board:

(A) Completed one year of an accredited residency, or an accredited or Board-approved clinical fellowship; or

(B) Been certified or recertified by a specialty board recognized by the American Board of Medical Specialties or the American Osteopathic Association; or

(c) The applicant has subsequently:

(A) Completed one year of an accredited residency, or

(B) Completed one year of an accredited or Board-approved clinical fellowship, or

(C) Been certified or recertified by a specialty board recognized by the American Board of Medical Specialties or the American Osteopathic Association, or

(D) Obtained continuing medical education to the Board's satisfaction.

(2) The applicant who has ceased the practice of medicine for a period of 24 or more consecutive months may be required to complete a re-entry plan to the satisfaction of the Board. The Board must

review and approve a re-entry plan prior to the applicant beginning the re-entry plan. Depending on the amount of time out-of-practice, the applicant may be required to do one or more of the following:

(a) Pass the SPEX/COMVEX examination;

(b) Practice for a specified period of time under a mentor/supervising physician who will provide periodic reports to the Board;

(c) Obtain certification or re-certification by a specialty board recognized by the American Board of Medical Specialties (ABMS) or the American Osteopathic Association's Bureau of Osteopathic Specialists (AOA-BOS);

(d) Complete a re-entry program as determined appropriate by the Board;

(e) Complete one year of accredited postgraduate or clinical fellowship training, which must be pre-approved by the Board's Medical Director;

(f) Complete at least 50 hours of Board-approved continuing medical education each year for the past three years.

(3) The applicant who fails the SPEX or COMVEX examination three times, whether in Oregon or other states, must successfully complete one year of an accredited residency or an accredited or Board-approved clinical fellowship before retaking the SPEX or COMVEX examination.

(4) The Limited License, SPEX/COMVEX may be granted for a period of up to 6 months. It permits the licensee to practice medicine only until the grade results of the SPEX or COMVEX examination are available and the applicant completes the initial registration process. If the applicant fails the SPEX or COMVEX examination, the Limited License SPEX/COMVEX becomes invalid, and the applicant must cease practice in this state as expeditiously as possible, but not to exceed two weeks after the applicant receives notice of failure of the examination.

(5) The applicant may be required to appear before the Board for a personal interview regarding information received during the processing of the application. The interview must be conducted during a regular meeting of the Board.

(6) All of the rules, regulations and statutory requirements pertaining to the medical school graduate remain in full effect.

Stat. Auth.: ORS 677.175, 677.265

Stats. Implemented: ORS 677.010, 677.175, 677.265

## **NORTH CAROLINA REENTRY RULE**

### **21 NCAC 32B .1370 REENTRY TO ACTIVE PRACTICE**

(a) A physician or physician assistant applicant ("applicant" or "licensee") who has not actively practiced or who has not maintained continued competency, as determined by the Board, for the two-year period immediately preceding the filing of an application for a license from the Board shall complete a reentry agreement as a condition of licensure.

(b) The applicant shall identify a mentoring physician.

(c) The applicant shall propose a reentry plan containing the components outlined in Paragraphs (g) and (h) of this Rule to the Board. The Board shall review the proposed reentry plan and interview the applicant.

(d) Factors that may affect the length and scope of the reentry plan include:

- (1) The applicant's amount of time out of practice;
- (2) The applicant's prior intensity of practice;
- (3) The reason for the interruption in practice;
- (4) The applicant's activities during the interruption in practice, including the amount of practice-relevant continuing medical education;
- (5) The applicant's previous and intended area(s) of practice;
- (6) The skills required of the intended area(s) of practice;
- (7) The amount of change in the intended area(s) of practice over the time the applicant has been out of continuous practice;
- (8) The applicant's number of years of graduate medical education;
- (9) The number of years since completion of graduate medical education; and
- (10) As applicable, the date of the most recent ABMS, AOA or equivalent specialty board, or National Commission on Certification of Physician Assistant certification or recertification.

(e) If the Board approves an applicant's reentry plan, it shall be incorporated by reference into a reentry agreement and executed by the applicant, the Board and the mentoring physician.

(f) After the reentry agreement has been executed, and the applicant has completed all other requirements for licensure, the applicant shall receive a restricted License. The licensee may not practice outside of the scope of the reentry agreement and its referenced reentry plan during the reentry period.

(g) The first component of a reentry plan is an assessment of the applicant's current strengths and weaknesses in his or her intended area of practice. The process used to perform the assessment shall be described by the applicant and confirmed by the mentoring physician. The process may include self-reflection, self-assessment, and testing and evaluation by colleagues, educators or others. The applicant and mentoring physician shall evaluate and describe applicant's strengths and areas of needed improvement in regard to the core competencies. The assessment shall continue throughout the reentry period as the licensee and the mentoring physician practice together.

(h) The second component of the reentry plan is education. Education shall address the licensee's areas of needed improvement. Education shall consist of:

- (1) a reentry period of retraining and education under the guidance of a mentoring physician, upon terms as the Board may decide, or
- (2) a reentry period of retraining and education under the guidance of a mentoring physician consisting of the following:
  - (A) Phase I – The observation phase. During the observation phase, the licensee will not practice, but will observe the mentoring physician in practice.
  - (B) Phase II – Direct supervision phase. During the direct supervision phase, the licensee shall practice under the direct supervision of the mentoring physician. Guided by the core competencies, the mentoring physician shall reassess the licensee's progress in addressing identified areas of needed improvement.
  - (C) Phase III – Indirect supervision phase. During the indirect supervision phase, the licensee shall continue to practice with supervision of the mentoring physician. Guided by the core competencies, and using review of patient charts and regular meetings, the mentoring physician shall reassess the licensee's progress in addressing the areas of needed improvement.
  - (D) No later than 30 days after the end of phase I and II, the mentoring physician shall send a report to the Board regarding the licensee's level of achievement in each of the core competencies. At the completion of phase III the mentoring physician shall submit a summary report to the Board regarding the licensee's level of achievement in each of the core competencies and affirm the licensee's suitability to resume practice as a physician or to resume practice as a physician assistant.
  - (E) If the mentoring physician reassesses the licensee and concludes that the licensee requires an extended reentry period or if additional areas of needed improvement are identified during Phases II or III, the Board, the licensee and the mentoring physician shall amend the reentry agreement.

(i) Under the terms of either reentry periods Subparagraph (h)(1) or (h)(2) of this Rule, the mentoring physician may terminate his role as the mentoring physician upon written notice to the Board. Such written notice shall state the reasons for termination. The licensee's approval is not required for the mentoring physician to terminate his role as mentoring physician. Upon receipt of the notice of termination, the Board shall place the licensee's license on inactive status. Within six months from the effective date of the mentoring physician's termination, the licensee shall provide a substitute mentoring physician, who must be approved by the Board in writing, and resume the reentry plan upon such terms as are acceptable to the Board. In such event, an amended reentry agreement must be executed prior to resumption of the reentry plan. If licensee does not resume the reentry plan as required herein within six months from the effective date of the mentoring physician's termination, then the Board shall not return the licensee to active status unless and until licensee applies and is approved for reactivation of the license with a new reentry agreement and reentry plan, which must be in place before licensee may resume practice as a physician or physician assistant.

(j) Under the terms of either reentry periods Subparagraph (h)(1) or (h)(2) of this Rule, the licensee may terminate the relationship with the mentoring physician upon written notice to the Board. Such written notice shall state the reasons for termination. The mentoring physician's approval is not required for the licensee to terminate this relationship. Upon receipt of the notice of termination, the Board shall place the licensee's license on inactive status. Within six months from the effective date of the mentoring physician's termination, the licensee shall provide a substitute mentoring physician, who must be approved by the Board in writing, and resume the reentry plan upon such terms as are

acceptable to the Board. In such event, an amended reentry agreement must be executed prior to resumption of the reentry plan. If licensee does not resume the reentry plan as required herein within six months from the effective date of the mentoring physician's termination, then the Board shall not return the licensee to active status unless and until licensee applies and is approved for reactivation of the license with a new reentry agreement and reentry plan, which must be in place before licensee may resume practice as a physician or physician assistant.

(k) The licensee shall meet with members of the Board at such dates, times and places as directed by the Board to discuss the licensee's transition back into practice and any other practice-related matters.

(l) Unsatisfactory completion of the reentry plan or practicing outside the scope of the reentry agreement, as determined by the Board, shall result in the automatic inactivation of the licensee's license, unless the licensee requests a hearing within 30 days of receiving notice from the Board.

(m) If the Board determines the licensee has successfully completed the reentry plan, the Board shall terminate the reentry agreement and notify the licensee that the license is no longer restricted.

*History Note: Authority G.S. 90-8.1; 90-14(a)(11a);  
Eff. March 1, 2011.*

## **NEBRASKA REENTRY LICENSE**

TITLE: Provide for reentry licenses under the Medicine and Surgery Practice Act

05/12/2011 PASSED ON FINAL READING 46-0-3.

05/12/2011 PRESIDENT/SPEAKER SIGNED.

05/12/2011 PRESENTED TO GOVERNOR ON MAY 12, 2011.

(1)(a) Present proof that he or she is a graduate of an accredited school or college of medicine, (b) if a foreign medical graduate, provide a copy of a permanent certificate issued by the Educational Commission on Foreign Medical Graduates that is currently effective and relates to such applicant or provide such credentials as are necessary to certify that such foreign medical graduate has successfully passed the Visa Qualifying Examination or its successor or equivalent examination required by the United States Department of Health and Human Services and the United States Citizenship and Immigration Services, or (c) if a graduate of a foreign medical school who has successfully completed a program of American medical training designated as the Fifth Pathway and who additionally has successfully passed the Educational Commission on Foreign Medical Graduates examination but has not yet received the permanent certificate attesting to the same, provide such credentials as certify the same to the Division of Public Health of the Department of Health and Human Services;

(2) Present proof that he or she has served at least one year of graduate medical education approved by the board or, if a foreign medical graduate, present proof that he or she has served at least three years of graduate medical education approved by the board;

(3) Pass a licensing examination approved by the board covering appropriate medical subjects; and

(4) Present proof satisfactory to the department that he or she, within the three years immediately preceding the application for licensure, (a) has been in the active practice of the profession of medicine and surgery in some other state, a territory, the District of Columbia, or Canada for a period of one year, (b) has had at least one year of graduate medical education as described in subdivision (2) of this section, (c) has completed continuing education in medicine and surgery approved by the board, (d) has completed a refresher course in medicine and surgery approved by the board, or (e) has completed the special purposes examination approved by the board.

Sec. 3. (1) The department, with the recommendation of the board, may issue a reentry license to a physician who has not actively practiced medicine for the two-year period immediately preceding the filing of an application for a reentry license or who has not otherwise maintained continued competency during such period as determined by the board.

(2) To qualify for a reentry license, the physician shall meet the same requirements for licensure as a regular licensee and submit to evaluations, assessments, and an educational program as required by the board.

(3) If the board conducts an assessment and determines that the applicant requires a period of supervised practice, the department, with the recommendation of the board, may issue a reentry license allowing the applicant to practice medicine under supervision as specified by the board. After satisfactory completion of the period of supervised practice as determined by the board, the reentry licensee may apply to the department to convert the reentry license to a license issued under section 38-2026.

(4) After an assessment and the completion of any educational program that has been prescribed, if the board determines that the applicant is competent and qualified to practice medicine without supervision, the department, with the recommendation of the board, may convert the reentry license to a license issued under section 38-2026.

(5) A reentry license shall be valid for one year and may be renewed for up to two additional years if approved by the department, with the recommendation of the board.

(6) The issuance of a reentry license shall not constitute a disciplinary action.

**ADDITIONAL LITERATURE ON REENTRY**

The following peer-reviewed articles provide a more in-depth overview and analysis of the issues associated with reentry.

Bower, EA, English C, Choi D, Cedfeldt AS, Girard DE. Education to return nonpracticing physicians to clinical activity: A case study in physician reentry. *Journal of Continuing Education in the Health Professions*. 2010;30(2):89-94.

Freed GL, Dunham KM, Abraham L. Protecting the public: State medical board licensure policies for active and inactive physicians. *Pediatrics*. 2009;123:643-652.

Kenagy GP, Schneidman BS, Barzansky B, Dalton C, Sirio CA, Skochelak SE. (2011). Physician reentry into clinical practice: Regulatory challenges. *Journal of Medical Regulation*. 2011;97(1):10-15.

Kenagy GP, Schneidman BS, Barzansky B, Dalton C, Sirio CA, Skochelak SE. Guiding principles for physician reentry programs. *Journal of Continuing Education in the Health Professions*. 2011;32(2):117-121.

Law MT, Hansen ZK. Medical licensing board characteristics and physician discipline: An empirical analysis. *Journal of Health Politics, Policy and Law*. 2010;35(1):63-93.

## ENDNOTES

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- <sup>1</sup> Bush F. Physician reentry to practice: A longstanding challenge with new relevance. *Journal of Medical Regulation*. 2010;96(1):4-5.
- <sup>2</sup> Federation of State Medical Boards. *FSMB Report Provides Roadmap for Maintenance of Licensure*. *Fsmb.org*. Press Release, April 28, 2010. Available at: <http://www.fsmb.org/pdf/mol-nr-042610.pdf>. Accessed September 4, 2011.
- <sup>3</sup> Grace ES, Korinek EJ, Weitzel LB, Wentz DK. Physicians reentering clinical practice: Characteristics and clinical abilities. *Journal of Continuing Education in the Health Professions*. 2011; 31(1):49-55.
- <sup>4</sup> Mulvey HJ, Jewett EA, Merline A, Towey KJ. Pediatricians over 50 reentering clinical practice: Implications for physicians and the regulatory community. *Journal of Medical Regulation*. 2010;96(2):7-12.
- <sup>5</sup> Mark S, Gupta J. Reentry into clinical practice: Challenges and strategies. *JAMA*. 2002;288:1091-1096.
- <sup>6</sup> Choudhry NK, Fletcher RH, Soumerai SB. Systematic review: The relationship between clinical experience and quality of health care. *Annals of Internal Medicine*. 2005;142(4):260-273.
- <sup>7</sup> Federation of State Medical Boards. *FSMB | Maintenance of Licensure*. Available at: <http://www.fsmb.org/mol.html>. Accessed January 21, 2011.
- <sup>8</sup> Chaudhry HJ, Rhyne J, Cain FE, Young A, Crane M, Bush F. Maintenance of licensure: Protecting the public, promoting quality health care. *Journal of Medical Regulation*. 2010; 96(2):13-20.
- <sup>9</sup> Bush F. Physician reentry to practice. *Journal of Medical Regulation*. 4-5.
- <sup>10</sup> Mulvey HJ, et al. Pediatricians over 50 reentering clinical practice. *Journal of Medical Regulation*. 7-12.
- <sup>11</sup> The Physician Reentry into the Workforce Project. *The Physician Reentry into the Workforce Project - Home*. Available at: <http://www.physicianreentry.org/>. Accessed January 20, 2011.
- <sup>12</sup> American Medical Association. *Physician Re-entry – Home*. Available at: [www.ama-assn.org/ama/pub/education-careers/finding-position/physician-reentry.shtml](http://www.ama-assn.org/ama/pub/education-careers/finding-position/physician-reentry.shtml). Access January 20, 2011.
- <sup>13</sup> Freed GL, Abraham LM, Brzoznowski KF. Inactive physicians: The state of our understanding. *The Journal of Pediatrics*. 2007;151(4):431-434.
- <sup>14</sup> Federation of State Medical Boards. Report of the Ad Hoc Committee in Physician Impairment. April 1995. Available at: [http://www.fsmb.org/pdf/1995\\_grpol\\_Physician\\_Impairment.pdf](http://www.fsmb.org/pdf/1995_grpol_Physician_Impairment.pdf).
- <sup>15</sup> The Physician Reentry into the Workforce Project. A physician reentry into the workforce inventory. Available at: [http://www.physicianreentry.org/yahoo\\_site\\_admin/assets/docs/Inventory\\_Checklist\\_Web\\_Version.10125922.pdf](http://www.physicianreentry.org/yahoo_site_admin/assets/docs/Inventory_Checklist_Web_Version.10125922.pdf).

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<sup>17</sup> Jewett EA, Brotherton SE, Ruch-Ross H. A national survey of 'inactive' physicians in the United States of America: Enticements to reentry. *Human Resources for Health*. 2011;9:7. Print.

<sup>18</sup> American Medical Association. *State Medical Licensure Requirements and Statistics 2011*. Chicago, IL: American Medical Association, 2010.

<sup>19</sup> Federation of State Medical Boards. *FSMB | Maintenance of Licensure*.

**PARTICIPANTS ON THE FSMB SPECIAL COMMITTEE  
ON REENTRY TO PRACTICE**

**COMMITTEE MEMBERS\***

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Former FSMB Interim President and CEO  
Former VP, AMA, Medical Education Group

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*\*Organizational affiliations are presented for purposes of identification and do not imply organizational approval of the Special Committee on Reentry to Practice work or content of this report.*

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Department of Safety & Professional Services**

**AGENDA REQUEST FORM**

<b>1) Name and Title of Person Submitting the Request:</b>  <b>Dale Kleven</b> <b>Administrative Rules Coordinator</b>		<b>2) Date When Request Submitted:</b>  <b>3/9/18</b> Items will be considered late if submitted after 12:00 p.m. on the deadline date: ▪ 8 business days before the meeting	
<b>3) Name of Board, Committee, Council, Sections:</b>  <b>Medical Examining Board</b>			
<b>4) Meeting Date:</b>  <b>3/21/18</b>	<b>5) Attachments:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<b>6) How should the item be titled on the agenda page?</b> <b>Legislative/Administrative Rule Matters:</b> <b>1. Scope Statement for Med 13 Relating to Continuing Medical Education</b> <b>2. Scope Statement for Med 20 Relating to Respiratory Care Practitioners</b> <b>3. Update on Other Legislation and Pending or Possible Rulemaking Projects</b>	
<b>7) Place Item in:</b> <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	<b>8) Is an appearance before the Board being scheduled?</b>  <input type="checkbox"/> Yes ( <a href="#">Fill out Board Appearance Request</a> ) <input checked="" type="checkbox"/> No	<b>9) Name of Case Advisor(s), if required:</b>	
<b>10) Describe the issue and action that should be addressed:</b>  _____  _____  _____			
<b>11)</b> <i><b>Dale Kleven</b></i>		Authorization  <i><b>March 9, 2018</b></i>	
Signature of person making this request		Date	
Supervisor (if required)		Date	
Executive Director signature (indicates approval to add post agenda deadline item to agenda)		Date	
<b>Directions for including supporting documents:</b> 1. This form should be attached to any documents submitted to the agenda. 2. Post Agenda Deadline items must be authorized by a Supervisor and the Policy Development Executive Director. 3. If necessary, Provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.			

# STATEMENT OF SCOPE

## Medical Examining Board

**Rule No.:** Med 13

**Relating to:** Continuing Medical Education for Physicians

**Rule Type:** Permanent

**1. Finding/nature of emergency (Emergency Rule only):**

N/A

**2. Detailed description of the objective of the proposed rule:**

The objective of the proposed rule is to promote best practices for prescribing controlled substances. The proposed rule would define the requirements for the completion of continuing education hours relating to prescribing controlled substances as a portion of the biennial training requirements for physicians.

**3. Description of the existing policies relevant to the rule, new policies proposed to be included in the rule, and an analysis of policy alternatives:**

Section 448.13, Stats., requires the completion of at least 30 hours of continuing medical education for biennial registration. Chapter Med 13 more precisely defines the requirements for continuing medical education. The chapter lists acceptable sources of continuing education, sets the standards for evidence of compliance with the requirements, and allows the Board to waive and audit the completion of continuing education requirements.

Current rules require a physician who holds a U.S. Drug Enforcement Administration number to complete 2 of the 30 required hours of continuing medical education from a Board-approved educational course or program related to the opioid prescribing guidelines issued by the Board. As this requirement expires after the current biennium, the proposed rule would define future requirements for the completion of continuing education hours related to prescribing controlled substances. The alternative to this rule change is to leave ch. Med 13 as written, which will not address the growing concern with prescription drug abuse.

**4. Detailed explanation of statutory authority for the rule (including the statutory citation and language):**

Section 15.08 (5) (b), Stats., provides examining boards, “shall promulgate rules for its own guidance and for the guidance of the trade or profession to which it pertains. . .”

Section 448.40 (1), Stats., provides that the Medical Examining Board “may promulgate rules to carry out the purposes of this subchapter, including rules requiring the completion of continuing education, professional development, and maintenance of certification or performance improvement or continuing medical education programs for renewal of a license to practice medicine and surgery.”

**5. Estimate of amount of time that state employees will spend developing the rule and of other resources necessary to develop the rule:**

60 hours

**6. List with description of all entities that may be affected by the proposed rule:**

Wisconsin licensed physicians

**7. Summary and preliminary comparison with any existing or proposed federal regulation that is intended to address the activities to be regulated by the proposed rule:**

None.

**8. Anticipated economic impact of implementing the rule (note if the rule is likely to have a significant economic impact on small businesses):**

The proposed rule will have minimal to no economic impact on small businesses and the state's economy as a whole.

**Contact Person:** Dale Kleven, Administrative Rule Coordinator, DSPSAdminRules@wisconsin.gov, (608) 261-4472

Approved for publication:

Approved for implementation:

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Date Submitted

\_\_\_\_\_  
Date Submitted

# STATEMENT OF SCOPE

## Medical Examining Board

Rule No.: Chapter Med 20

Relating to: Respiratory Care Practitioners

Rule Type: Permanent

### 1. Finding/nature of emergency (Emergency Rule only):

None.

### 2. Detailed description of the objective of the proposed rule:

The objective of the proposed rule is to evaluate and update ch. Med 20 relating to respiratory care practitioners to ensure it is consistent with current examination and licensing practices and applicable Wisconsin statutes.

### 3. Description of the existing policies relevant to the rule, new policies proposed to be included in the rule, and an analysis of policy alternatives:

Current administrative rules define and reference the acronym “CRTT” (Certified Respiratory Therapy Technician). The proposed rules will replace “CRTT” with “CRT” (Certified Respiratory Therapist) to reflect current terminology.

Effective January 2015, the National Board for Respiratory Care (NBRC) changed the Certified Respiratory Technician examination from the Entry Level CRT Examination to the Therapist Multiple-Choice Examination (TMC). The proposed rules will update terminology and administrative provisions related to the NBRC examination.

The proposed rules will revise s. Med 20.04 (7) to clarify the requirement for completion of further professional training or education prescribed by the Board before retaking an exam after a third failure does not apply to the NBRC examination.

Section Med 20.05 allows the Board to issue a temporary certificate to practice respiratory care to a candidate who has not received the results of the NBRC examination but is otherwise qualified for certification. This provision was created at a time when results of an examination could take several months. As results of the current NBRC examination are available immediately, the temporary certificate under s. Med 20.05 is no longer necessary. The proposed rules will repeal s. Med 20.05 in its entirety.

The Respiratory Care Practitioners Examining Council will evaluate the provisions of ch. Med 20 and may propose other changes to ensure consistency with current examination and licensing practices and applicable Wisconsin Statutes. The alternative of not evaluating and updating these rules as described above would be less beneficial to affected entities.

### 4. Detailed explanation of statutory authority for the rule (including the statutory citation and language):

Section 15.08 (5) (b), Stats., provides an examining board “shall promulgate rules for its own guidance and for the guidance of the trade or profession to which it pertains. . .”

Section 448.05 (5r), Stats., provides “[a]n applicant for a certificate or a temporary certificate to practice respiratory care shall submit evidence satisfactory to the board that the applicant is a graduate of a school with a course of instruction in respiratory care approved by the commission on accreditation of allied health education programs of the American Medical Association.”

Section 448.05 (6), Stats., provides “. . . the board shall examine each applicant it finds eligible under this section in such subject matters as the board deems applicable to the class of license or certificate which the applicant seeks to have granted. Examinations may be both written and oral.”

Section 448.06 (2), Stats., provides “[t]he board may deny an application for any class of license or certificate and refuse to grant such license or certificate on the basis of unprofessional conduct on the part of the applicant, failure to possess the education and training required for that class of license or certificate for which application is made, or failure to achieve a passing grade in the required examinations.”

**5. Estimate of amount of time that state employees will spend developing the rule and of other resources necessary to develop the rule:**

State employees will spend approximately 80 hours developing the proposed rule.

**6. List with description of all entities that may be affected by the proposed rule:**

Applicants for a certificate to practice respiratory care

**7. Summary and preliminary comparison with any existing or proposed federal regulation that is intended to address the activities to be regulated by the proposed rule:**

None.

**8. Anticipated economic impact of implementing the rule (note if the rule is likely to have a significant economic impact on small businesses):**

The proposed rule will have minimal to no economic impact on small businesses and the state’s economy as a whole.

**Contact Person:** Dale Kleven, DSPSAdminRules@wisconsin.gov, (608) 261-4472

Approved for publication:

Approved for implementation:

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Date Submitted

\_\_\_\_\_  
Date Submitted

## AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request:  Andrea Magermans		2) Date When Request Submitted:  03/12/2018 Items will be considered late if submitted after 12:00 p.m. on the deadline date which is 8 business days before the meeting																						
3) Name of Board, Committee, Council, Sections: Medical Examining Board																								
4) Meeting Date: 03/21/18	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page?  PDMP Referrals – Discussion and Consideration																						
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session	8) Is an appearance before the Board being scheduled?  <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	9) Name of Case Advisor(s), if required:																						
10) Describe the issue and action that should be addressed:  Discussion of criteria for CSB/PDMP Referrals, based on the following motions from 3/9/18 CSB meeting:  <u>Discussion of Disclosures of PDMP Data to Relevant Boards Under CSB 4.15(5)</u> MOTION: Leonardo Huck moved, seconded by Yvonne Bellay, to create a Work Group of Peter Kallio, Timothy Westlake, Doug Englebert, and Philip Trapskin to develop criteria for analyzing prescribing and dispensing practices that should be brought to the Board’s attention. Motion carried unanimously.  MOTION: Peter Kallio moved, seconded by Yvonne Bellay, to request that the Department place an appearance by PDMP staff for the following Boards at their next meeting: Board of Nursing, Medical Examining Board, Dentistry Examining Board, Optometry Examining Board, Podiatry Affiliated Credentialing Board and Pharmacy Examining Board. Motion carried unanimously.  CSB 4.15 is attached, for reference.																								
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%;"></td> <td style="width: 20%; text-align: center;"><b>Authorization</b></td> <td style="width: 20%;"></td> </tr> <tr> <td style="border-bottom: 1px solid black;">Signature of person making this request</td> <td style="border-bottom: 1px solid black;"></td> <td style="border-bottom: 1px solid black;">Date</td> </tr> <tr> <td style="border-bottom: 1px solid black;">Andrea Magermans 3/12/18</td> <td style="border-bottom: 1px solid black;"></td> <td style="border-bottom: 1px solid black;"></td> </tr> <tr> <td style="border-bottom: 1px solid black;">Supervisor (if required)</td> <td style="border-bottom: 1px solid black;"></td> <td style="border-bottom: 1px solid black;">Date</td> </tr> <tr> <td style="border-bottom: 1px solid black;"></td> <td style="border-bottom: 1px solid black;"></td> <td style="border-bottom: 1px solid black;"></td> </tr> <tr> <td colspan="2" style="border-bottom: 1px solid black;">Executive Director signature (indicates approval to add post agenda deadline item to agenda)</td> <td style="border-bottom: 1px solid black;">Date</td> </tr> <tr> <td colspan="2" style="border-bottom: 1px solid black;"></td> <td style="border-bottom: 1px solid black;"></td> </tr> </table>					<b>Authorization</b>		Signature of person making this request		Date	Andrea Magermans 3/12/18			Supervisor (if required)		Date				Executive Director signature (indicates approval to add post agenda deadline item to agenda)		Date			
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Directions for including supporting documents: 1. This form should be attached to any documents submitted to the agenda. 2. Post Agenda Deadline items must be authorized by a Supervisor and the Policy Development Executive Director. 3. If necessary, provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.																								

**CSB 4.15 Disclosure of suspicious or critically dangerous conduct or practices.**

- (1) The board may review dispensing data, monitored prescription drug history reports, PDMP data, and data compiled pursuant to s. CSB 4.12 to determine whether circumstances indicate suspicious or critically dangerous conduct or practices of a pharmacist, pharmacy, practitioner, or patient.
- (2) The board may include any of the following factors when determining whether circumstances indicate suspicious or critically dangerous conduct or practices of a pharmacist or pharmacy:
  - (a) The pharmacist or pharmacy's monitored prescription drug dispensing practices deviate from accepted pharmacist or pharmacy practices.
  - (b) There are unusual patterns in the payment methodology used by patients to whom monitored prescription drugs are dispensed by the pharmacist or pharmacy.
  - (c) The history of actions taken against the pharmacist or pharmacy by other state agencies, agencies of another state, or law enforcement.
  - (d) The type and number of monitored prescription drugs dispensed by the pharmacist or at the pharmacy.
  - (e) The pharmacist or pharmacy has dispensed forged prescription orders for a monitored prescription drug.
  - (f) The distance patients travel to have monitored prescription drugs dispensed at the pharmacy.
  - (g) The number of patients dispensed monitored prescription drugs at the pharmacy or by the pharmacist who satisfy any of the criteria identified in sub. (4).
- (3) The board may include any of the following factors when determining whether circumstances indicate suspicious or critically dangerous conduct or practices of a practitioner:
  - (a) The practitioner's monitored prescription drug prescribing practices deviate from accepted prescribing practices.
  - (b) The practitioner prescribes potentially dangerous combinations of monitored prescription drugs to the same patient.
  - (c) The type and number of monitored prescription drugs prescribed by the practitioner.
  - (d) The history of actions taken against the practitioner by other state agencies, agencies of another state, or law enforcement.
  - (e) The distance patients travel to obtain monitored prescription drug prescriptions from the practitioner.
  - (f) The number of patients to whom the practitioner prescribed a monitored prescription who satisfy any of the criteria identified in sub. (4).
- (4) The board may include any of the following factors when determining whether circumstances indicate suspicious or critically dangerous conduct or practices of a patient:
  - (a) The number of practitioners from whom the patient has obtained a prescription for a monitored prescription drug.
  - (b) The number of pharmacies from where the patient was dispensed a monitored prescription drug.
  - (c) The number of prescriptions for a monitored prescription drug obtained by the patient.
  - (d) The number of monitored prescription drug doses dispensed to the patient.
  - (e) Whether the monitored prescription drugs dispensed to the patient include dangerous levels of any drug.
  - (f) The number of times the patient is prescribed or dispensed a monitored prescription drug before the previously dispensed amount of the same or a similar monitored prescription drug would be expected to end.
  - (g) The payment methodology used by the patient to obtain controlled substances at a pharmacy.
- (5) Upon determining that circumstances indicate suspicious or critically dangerous conduct or practices of a pharmacy, practitioner, or patient, the Board may disclose monitored prescription drug history reports, audit trails, and PDMP data to any of the following:
  - (a) A relevant patient.
  - (b) A relevant pharmacist or practitioner.
  - (c) A relevant state board or agency.
  - (d) A relevant agency of another state.
  - (e) A relevant law enforcement agency.
- (6) Upon determining that a criminal violation may have occurred, the board may refer a pharmacist, pharmacy, or practitioner to the appropriate law enforcement agency for investigation and possible prosecution. The board may disclose monitored prescription drug history reports, audit trails, and PDMP data to the law enforcement agency as part of the referral.