

# TENNESSEE BOARD OF MEDICAL EXAMINERS

## Report on Physician Reentry

### BACKGROUND

When physicians leave clinical practice, they may do so voluntarily or involuntarily. Physicians may leave to pursue other career opportunities such as administrative medicine, to take care of family members, or to pursue leisure activities. They may do so with the intent to return to clinical practice at a later date or may intend to retire after a long career. The hiatus may also be the result of a disciplinary action or the consequence of a physical health, mental health, or substance use issue. Whatever the cause of their departure, physicians who have left practice and later choose to return to clinical medicine, must be prepared to demonstrate that they have maintained their skills and knowledge, and that they may safely and effectively resume providing care to patients.

It is for this reason—patient safety—that state medical boards are concerned with the issue of physician reentry. These boards are the gatekeepers of safe medical care and effective guarding of the gate requires them to consider competency a dynamic, rather than a static, construct. A physician may qualify for medical licensure insofar as he or she possesses all of the required education and training; however, an extended period of time away from clinical practice brings a physician's *current* knowledge and *current* competence into question and may put patients at risk of bad outcomes.

In recent years, the Tennessee Board of Medical Examiners (the “Board”) has encountered an increasing number of physicians who are seeking medical licensure after some period of clinical inactivity. The Board has dealt with these applicants on a case-by-case basis, but ultimately determined that a taskforce of the Board should be empowered to thoroughly consider the issue of physician reentry and submit recommendations to be considered by the full Board. This document seeks to summarize the Taskforce's deliberations and to assist in standardizing a process by which a reentry candidate may demonstrate or regain clinical competency. It is intended to apply to applicants who are applying for initial licensure in Tennessee or for reinstatement of a previously active Tennessee medical license. A secondary goal of this document is to educate physicians who are considering a departure from active clinical practice on the pathway to reinstatement of medical licensure. The Taskforce believes that increasing awareness of the Board's reentry requirements is essential to ensuring not only those physicians are prepared for reentry, but that they have the proper framework within which to make a decision regarding their possible departure from medical practice.

### WHEN DOES AN APPLICANT BECOME A REENTRY CANDIDATE?

The Board, like a majority of state medical boards across the country with a reentry trigger, has established by rule that a physician's absence from clinical practice for more than two years creates a presumption of clinical incompetence that may be rebutted in a variety of ways. The Board's

“reactivation rule,” grants the Board discretion to require an applicant to appear for an interview to address “continued competence in the event of licensure retirement or inactivity in excess of two years.”<sup>vi</sup> In these situations, the Board is also permitted to place other conditions or restrictions on the applicant as the Board deems necessary to protect the public. The examination rules authorize the Board to require an applicant to take and pass the SPEX examination when the applicant has not engaged in the clinical practice of medicine for more than two years.<sup>ii</sup>

Though there is little evidence suggesting that more than two years of clinical inactivity is the most appropriate “trigger” for application of a physician reentry policy, this amount of inactivity has nonetheless emerged as the baseline among many state medical boards.<sup>iii</sup> According to a poll of state medical boards conducted by the American Medical Association (AMA) in 2013, of the 37 boards acknowledging a reentry trigger, thirteen of them reported that two or more years of clinical inactivity would necessitate that an applicant complete a reentry program,<sup>iv</sup> 7 reported a five year trigger<sup>v</sup> and 2 required an applicant to submit to a reentry program after just one year away from practice.<sup>vi</sup> While there may be inadequate evidence to authoritatively establish two years as the only appropriate trigger for application of a reentry policy, evidence does support that a physician’s clinical skills do begin to decline after time away from active practice.<sup>vii</sup>

**Table 1. Rating on Assessment by Years Out of Practice: Range of Performance and Average Rating**

	<i>Performance Rating<sup>1</sup></i>				<i>Total</i>	<i>Average Rating</i>
	<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>		
<i>Years Out of Practice</i>	<i>Number of Physicians Achieving Each Rating</i>					
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: Table Reproduced from CPEP’s “Physicians Reentering Clinical Practice: Characteristics and Clinical Abilities”**

This concept is supported anecdotally by the reentry applicants who appear before the Board. Not uncommonly a reentry candidate who has had a period of clinical activity will discuss their own remediation plans because they do not feel comfortable resuming medical practice immediately upon licensure and have some personal plans to remediate. While responsible, conscientious providers may make and execute personal remediation plans, the Board’s involvement is necessary to ensure that all possible protections are afforded healthcare consumers in our state. Self-regulation is a generally worthy concept, but it is unreliable in the reentry context mostly because it can be incredibly difficult for a physician who has been out of practice for an extended period of time to reasonably evaluate his or her knowledge and skills. In other words, how does one know what one does not know?

Most of the Board’s recent<sup>viii</sup> reentry candidates have been out of clinical activity entirely, with no intermittent or clinical practice of any kind; however, the Taskforce recognizes that this may not always be the case. An applicant for medical licensure in Tennessee may maintain a license in one or more states and occasionally practice medicine in that state by providing charity care or doing locum tenens work. Accordingly, the Taskforce feels that it is necessary to specify that a physician may be said to be in active clinical practice when any amount of direct patient care has been provided by the applicant in the preceding 2 years. Direct patient care has been provided when a physician treats, or professes to

<sup>1</sup> Physicians were rated from 1 (no or limited education needs) to 4 (global, pervasive deficits).

diagnose, treat, operate on or prescribe for any physical ailment or any physical injury to or deformity of another.<sup>ix</sup> The reentry candidate shall have the burden of providing appropriate proof of direct patient care. Ideally, such proof will include a patient chart but may include other documentation as deemed appropriate by the Board. The 24 month period should begin from the date the physician last provided direct patient care and will be tolled by the filing of an application for medical licensure in the Board’s administrative office. The Board should consider the physician’s clinical activities and length of time in practice prior to departure, as well as his or her intended future practice activities when considering how to craft an appropriate reentry plan and determining whether reentry is appropriate. Generally, reentry is appropriate when a physician is returning to a specialty in which he or she was previously engaged.<sup>x</sup> When a physician returns to practice and enters a new specialty after two or more years of clinical inactivity, retraining, rather than reentry, is needed.

## ASSESSING A REENTRY CANDIDATE’S CURRENT COMPETENCE

A physician’s absence from clinical practice for more than two years creates a presumption of clinical incompetence, but that presumption is rebuttable. Some physicians who have been out of practice for more than two years will be able to overcome that presumption by successfully completing an examination or by submitting to a knowledge and/or skills assessment by a Board-sanctioned organization. Recent retraining and recertification may obviate the need for an assessment altogether if the activity is recent and comprehensive.

Accordingly, applicants who have been identified as reentry candidates or those undergoing retraining should, in most cases, be given an opportunity to prove their clinical competence before a formal remediation plan is developed and required. A remediation plan is the plan developed by the Board to cure any knowledge or skill deficiencies identified by an assessment. The reentry plan is the plan developed by the Board to assess, and if necessary, remediate the reentry candidate. The Taskforce recommends that the Board utilize the following assessment tools to determine whether formal remediation should be required.

**Table 2**

<i>More than 2 years and up to 5 years out of practice</i>	<i>Successful completion of the SPEX Examination may satisfy competency requirement.</i>
	<i>Successful completion of certification examination (initial or recertification) may satisfy competency requirement.</i>
	<i>Formal assessment may be required.</i>
<i>More than 5 years and up to 10 years out of practice</i>	<i>Successful completion of certification examination (initial or recertification) may satisfy competency requirement as appropriate.</i>
	<i>Formal assessment may be required.</i>
<i>More than 10 years out of practice</i>	<i>Formal assessment will be required.</i>

## The Special Purpose Examination (SPEX)

By rule, when an applicant has not practiced clinically for *more than* two years, the Board has the authority to require the applicant to take and pass the SPEX examination.<sup>xi</sup> The SPEX examination is administered jointly by the Federation of State Medical Boards (FSMB) and the National Board of Medical Examiners (NBME): the same organizations that jointly administer the United State Medical Licensure Examination (USMLE). The SPEX is an online, general knowledge, one-day examination consisting mainly of USMLE Step 3 items. Historically, the pass rate for the SPEX has been between 70 – 75%, though recent data shows a pass rate hovering right around 70%. The SPEX is a cost-efficient assessment tool. While the cost of the examination is \$1,300.00, a practice test, test questions and study materials are available through the FSMB’s website at no cost.

Any physician with an active state medical license may self-nominate for the SPEX, which means that a physician may take a SPEX examination without any prompting from the Board. Approximately 45% of all current SPEX takers are self-nominated. The remaining 65% of SPEX takers are sponsored by a state medical board. In cases of a board referral, the scores are released to the applicant and the referring board. When a physician self-nominates for the SPEX, the score is released only to that physician.

According to the NBME, “appropriate candidates for the SPEX include physicians seeking licensure reinstatement or reactivation after some period of professional inactivity, or physicians involved in disciplinary proceedings in which the state medical board determines the need for evaluation.”<sup>xii</sup> Neither the NBME nor the FSMB have publicized a recommendation regarding what period of professional inactivity might disqualify a physician from being an appropriate SPEX candidate; however, it is the Taskforce’s belief that the SPEX should only be utilized by physicians who have been out of clinical practice for fewer than five years. Physicians who have been out of practice for more than two but less than three years should have the option to take the SPEX without consideration of other factors, such as intended specialty area. Physicians who have been out of practice for more than three but less than five years may be permitted to take the SPEX; however, when determining whether a physician will be permitted to take the SPEX to prove competency, the Board should also consider the amount of time the physician spent in postgraduate training, his or her prior practice area and intended specialty area.

## ABMS Certification/Recertification Examination

Though both licensure and certification exist to ensure the safety and wellness of healthcare consumers by establishing high standards of professionalism and practice, the concepts occupy different spheres of a physician’s career that may never overlap. A physician does not have to be board certified to be licensed and the Taskforce and Board do not take a position as to whether Tennessee physicians should seek specialty certification. Nevertheless, according to the most recent data available, in 2014 there were 19,362 medical doctors licensed in the state of Tennessee and 15,335 ABMS specialty certificates issued to Tennessee physicians.<sup>xiii</sup> Clearly, board certification is a credential many physicians choose to pursue. Once board certification is achieved in a specialty, specialties or subspecialty, a physician must decide whether to maintain that certification through the maintenance of certification (MOC) process developed by the certifying body. While the MOC process can vary substantially from specialty board to specialty board, initial certification is uniformly achieved through the successful completion of an approved residency and an examination or examinations.

The ABMS’ “Standards for Initial Certification” states that the overall examination process for initial certification “is intended to provide patients, health care organizations, and the profession with a dependable mechanism for identifying specialists who have met standards for the specialty. This requires

an assessment of the candidates' mastery of the core knowledge, judgment and skills in the specialty."<sup>xiv</sup> Consistent with this standard, the Taskforce believes that the initial certification examination is a reliable measure of a physician's competency in a particular specialty. The Taskforce recommends that physicians who have been out of practice for more than two and less than five years, but who have, in the 12 months immediately preceding the date of the physician's application for licensure, successfully completed an initial certification examination in an ABMS specialty or subspecialty be deemed competent in that specialty or subspecialty. For the purpose of this report, initial certification means that the physician has been certified in the specialty for the first time, or has been recertified in a specialty in which he or she previously held a specialty board certification. Recertification does not refer to the scheduled assessment and/or activities required to meet the requirements for maintenance of certification on an ongoing, uninterrupted basis.

As of this writing, the ABMS member boards are actively discussing whether to phase out the "high stakes" recertification examinations utilized by some of the boards in favor of alternate, more continuous ways of assessing a physician's medical knowledge.<sup>xv</sup> While the Taskforce does not take a position on whether a high stakes recertification examination is essential to the MOC process, those physicians who have chosen to take and have successfully completed a recertification examination may request that the Board consider that examination as sufficient proof of current competency in that specialty area so long as the physician's total length of clinical inactivity does not exceed five years and the recertification examination was completed in the twelve months immediately preceding the date the physician's application is received in the administrative office. If a physician's period of clinical inactivity is greater than five but less than or equal to ten years, a recently completed certification or recertification examination may be considered as proof of competency on a case-by-case basis. In these situations, due consideration must be given to the number of years the physician spent in postgraduate training, the number of years spent in clinical medicine before any interruption in practice, the physician's activities since the interruption in practice, as well as his or her prior practice area and intended specialty.

### **Formal Assessment by a Collaborating Assessment Program**

If none of the aforementioned assessment tools are appropriate given a reentry candidate's unique circumstances, the Board should require that a formal assessment of the physician's medical knowledge and clinical skills be completed to either confirm that remediation is not necessary, or to take the first step in developing a remediation program that is crafted to the physician's knowledge and clinical deficiencies. Generally, a formal assessment will be required when the reentry candidate has been out of clinical practice for more than ten years but *may* be required when a candidate has been out of practice for more than five years.

The Taskforce recognizes that an assessment can be logistically difficult and expensive to complete; however, without a formal assessment it may be impossible for the Board to establish with reasonable certainty that a physician's length of time out of practice has not resulted in diminished medical knowledge and skills such that they are unprepared to return to clinical practice. In an effort to ease the burden of undergoing a formal assessment, the Taskforce recommends that the Board make every effort to allow a reentry candidate to select his or her own assessment program so long as the selected program specializes in assessing clinical competency and is recognized as a collaborator with the FSMB's Post-Licensure Assessment System (PLAS).<sup>xvi</sup>

## REMEDIATING A REENTRY CANDIDATE

Once a reentry candidate's clinical skills and knowledge have been assessed, the Board can begin developing a remediation program that addresses *that* particular candidate's current and *specific* skills or knowledge deficiencies. The Taskforce believes that the remediation tools discussed in this section either alone or in combination can be used to form a custom remediation plan for any candidate the Board encounters. The Taskforce urges the Board to be consistent in its development of remediation plans, yet flexible; appropriately considering each applicant's unique circumstances while aiming for predictability. Both goals are important to ensuring consistency in the Board's deliberation and fairness to its applicants and licensees.

As important as consistency is, it is subservient to the Board's obligation to protect the public, and does not require that the Board treat every reentry case in exactly the same manner. Reentry candidates must be aware and anticipate that their remediation plan may not look exactly like another candidate's. A neurosurgeon who has had a long interruption of clinical practice should not expect to be evaluated or remediated the same way as a general practice physician would be after a brief interruption in practice. The Taskforce offers this report to licensees as a guide rather than a directive.

### Continuing Medical Education

It is the Board's hope that any physician who leaves practice with any possibility of returning will continue to complete continuing medical education courses during their period of clinical inactivity. Good quality CME is a valuable exercise and should be a part of any medical practitioner's commitment to lifelong learning. And while CME is likely to be a part of many remediation plans, it is unlikely to be the sole remediation activity recommended for a reentry candidate. An exception to that general rule might be when a practitioner's deficiency is minimal and specific, and high quality, in-person CME exists addressing the practitioner's particular need. For example, a practitioner who is found to have adequate knowledge in all assessed areas, but is somewhat deficient in prescribing might be able to cure that single knowledge deficiency with CME; however, such a decision will be made on a case-by-case basis.

### Preceptorships

The Board has used preceptors to remediate reentry candidates in the past. In those instances, the Board allowed a reentry candidate to select a preceptor, submit the name and practice area of the preceptor to the Board or the Board's medical consultant for approval, and remediate in a supervised setting. The reentry candidate did not have a license, so no patient care could be provided; however, the Board expected that the preceptor would allow the reentry candidate to exercise clinical judgments and interact with patients so that the preceptor could reasonably assess the physician's knowledge, skills, and comfort with patients and in the clinical setting generally.

Preceptors are used as a remediation tool in other Tennessee health professions and by other state medical boards. They solve the logistical and economic problems caused by expensive and geographically rare formal assessment programs. What they offer in access and affordability may not be enough to overcome the questions raised by their quality and reliability. The Board is not, after all, especially well-equipped to evaluate a physician's ability to serve as a preceptor. And the preceptors who agree to take on a reentry candidate may not be especially well-equipped to evaluate their remediation ability either. Without a formal assessment and recommendations by a professional organization that specializes in assessing competency, formulating an effective remediation plan may be difficult.



For these reasons, the Taskforce suggests that preceptors will be most appropriate when a prior formal assessment has been done by a PLAS collaborating organization. Any deficiencies noted should be reviewed by the preceptor and used to develop a remediation plan and post-remediation assessment. The preceptor, remediation plan and assessment must be reviewed and approved by the Board, the Board's consultant or other designee. Once the Board, consultant or designee has sanctioned the remediation program, the terms of the preceptorship should be reduced to writing and a deadline for completion of the program noted.

When selecting a preceptor, the Taskforce offers the following recommendations:

- The preceptor should practice in the same practice area as the licensee's training and intended practice area.
- The preceptor should not have an existing relationship with the applicant such that the preceptor cannot exercise independent judgment in his or her evaluation of the applicant.
- The candidate must verify the licensure of the preceptor to confirm that he or she is licensed to practice medicine in Tennessee and not subject to any discipline.

The Taskforce is aware that some preceptors are paid for their services but does not take a position on the topic. Whether a preceptor will be paid is an agreement to be reached between the reentry candidate and the preceptor and all of the terms of the agreement, including compensation, should be reduced to a formal, written agreement. The parties should also discuss and formalize in detail, what happens if the preceptor does not believe that the reentry candidate has been successfully remediated. For example, will the preceptorship resume until remediation has been successful? Is the relationship terminated? This is a particularly important conversation to have when the preceptor is being compensated for his or her work.

While it may be impossible for a preceptor, or assessment program, for that matter, to determine with absolute certainty that a physician is safe to reenter practice, it is the position of the Taskforce that a preceptor who falsely attests to a reentry candidate's competence has committed unprofessional conduct and may be subject to discipline. A preceptor who agrees to remediate a reentry candidate should take the role very seriously and only agree to serve as a preceptor if it is well within her abilities and comfort.

### **Formal Remediation by a PLAS Collaborator**

A reentry candidate should always have the option to undergo formal remediation by a PLAS collaborating organization. These formal programs offer experts, monitoring, plans and post-remediation assessments. For those with the resources and the ability to travel, these programs may be the quickest, most predictable way to reenter practice. For others who demonstrate the need for such a structured program, this may be the only way to remediate. The Taskforce recommends that the Board reserve and when appropriate, exercise its right to require a reentry candidate to undergo formal remediation at a PLAS collaborating program. The Taskforce believes that a physician who has been out of practice for more than ten years will virtually always have to remediate through a formal program under the monitoring and supervision of trained professionals.

A physician who is considering reentry is advised to complete an application for licensure before enrolling in a formal remediation program to allow the Board and its staff the opportunity to evaluate the physician's general credentials. A physician's remediation does not obviate the independent need to satisfy the statutory requirements for licensure.

## Conclusion

While the workforce and physician shortage debate wears on, insufficient access to primary and specialty care in many areas, including many areas of Tennessee, is observable and beyond dispute.<sup>xvii</sup> To the extent it can safely do so, the Board has an obligation to facilitate the efficient and effective reentry of capable physicians to the workforce. Likewise, physicians have an obligation to educate themselves on the reality of reentry and the Board's expectations. Properly planning an exit from clinical care will go a long way towards ensuring a smooth reentry process. With this report, the Board hopes to have taken the first steps towards fulfilling its obligation to its licensees and the public.



## ENDNOTES

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<sup>i</sup> TENN. COMP. R. & REGS. 0880-02-.10(3)(c).

<sup>ii</sup> TENN. COMP. R. & REGS. 0880-02-.08(3).

<sup>iii</sup> Federation of State Medical Boards. *Report of the Special Committee on Reentry to Practice*. Available at: <https://www.fsmb.org/Media/Default/PDF/FSMB/Advocacy/pub-sp-cmt-reentry.pdf>.

<sup>iv</sup> The American Medical Association. *State Medical Licensure Requirements and Statistics, 2013*.

<sup>v</sup> Ibid.

<sup>vi</sup> Five SMBs required reentry after a three year interruption in practice; five boards set the trigger at 4 years; two at the Board's discretion; and one at eighteen months.

<sup>vii</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 Winter; 31(1):49-55.

<sup>viii</sup> American Board of Medical Specialties. 2013-2014 ABMS Board Certification Report. Available at: [http://www.abms.org/media/84770/2013\\_2014\\_abmscertreport.pdf](http://www.abms.org/media/84770/2013_2014_abmscertreport.pdf). 27.

<sup>ix</sup> TENN. CODE ANN. § 63-6-204(a)(1).

<sup>x</sup> Physician Reentry into the Workforce Project. *The Physician Reentry into the Workforce Project – Home*. Available at: <http://physician-reentry.org/>.

<sup>xi</sup> TENN. COMP. R. & REGS. 0880-02-.08(3).

<sup>xii</sup> National Board of Medical Examiners. *NBME – SPEX*. Available at: <http://www.nbme.org/clinicians/spex.html>.

<sup>xiii</sup> American Board of Medical Specialties. 2013-2014 ABMS Board Certification Report. Available at: [http://www.abms.org/media/84770/2013\\_2014\\_abmscertreport.pdf](http://www.abms.org/media/84770/2013_2014_abmscertreport.pdf). 30.

<sup>xiv</sup> American Board of Medical Specialties. *Response to the American Medical Association Policy on Secure Recertification Exam*. Available at: <http://www.abms.org/news-events/response-to-the-american-medical-association-policy-on-secure-recertification-exam/>.

<sup>xv</sup> Cheryl, Clark. Meeting Coverage: AMA 'Pans' High Stakes Exam. *MedPage Today*. Meeting Coverage, June 16, 2016. Available at: <http://www.medpagetoday.com/meetingcoverage/ama/58594>.

<sup>xvi</sup> Federation of State Medical Boards. *Physician Assessment Resources – Assessment Programs, Tools, & Referral Process*. Available at: [http://www.fsmb.org/licensure/spex\\_plas/physician-assessment-referral-process](http://www.fsmb.org/licensure/spex_plas/physician-assessment-referral-process).

<sup>xvii</sup> [https://www.aamc.org/download/458082/data/2016\\_complexities\\_of\\_supply\\_and\\_demand\\_projections.pdf](https://www.aamc.org/download/458082/data/2016_complexities_of_supply_and_demand_projections.pdf).