



IOWA BOARD OF MEDICINE
400 SW 8TH - SUITE C
DES MOINES IA 50319
SEPTEMBER 22-23, 2011 BOARD MEETING

THURSDAY, SEPTEMBER 22, 2011

- 7:30 a.m. EXECUTIVE COMMITTEE – CLOSED SESSION¹ - Medical Conference Room B**
Chair Siroos Shirazi, M.D., Tom Drew, Analisa Haberman, D.O., Jeffrey Snyder, M.D., Colleen Stockdale, M.D.
- 8:00 a.m. SCREENING COMMITTEE – CLOSED SESSION¹ – Shared Conference Room**
Chair Ambreen Mian, Diane Clark, Greg Hoversten, D.O., Hamed Tewfik, M.D., Joyce Vista-Wayne, M.D.
- 9:00 a.m. MONITORING COMMITTEE – CLOSED SESSION¹ – Shared Conference Room**
Chair Joyce Vista-Wayne, M.D., Analisa Haberman, D.O., Greg Hoversten, D.O., Ambreen Mian, Hamed Tewfik, M.D.
- 9:30 a.m. LICENSURE COMMITTEE – CLOSED SESSION¹ - Medical Conference Room B**
Chair Colleen Stockdale, M.D., Diane Clark, Tom Drew, Siroos Shirazi, M.D., Jeffrey Snyder, M.D.
- FULL BOARD – CLOSED SESSION¹ - Shared Conference Room**
Chair Shirazi, Vice Chair Snyder, Secretary Stockdale, Clark, Drew, Haberman, Hoversten, Mian, Tewfik, Vista-Wayne
- A. Iowa Physician Health Committee**
- 1. Notices of non-compliance**

LUNCH BREAK

FULL BOARD – CLOSED SESSION¹ - Shared Conference Room
Shirazi, Clark, Drew, Haberman, Hoversten, Mian, Snyder, Stockdale, Tewfik, Vista-Wayne

**1:30 p.m. to 3:00 p.m. BREAK TO ACCOMMODATE BOARD'S OPEN HOUSE, 2 TO 3 P.M.
(SEE ATTACHED NOTICE)**

**3:15 p.m. PUBLIC (SESSION) – Iowa Board of Medicine, 400 SW Eighth, Suite C,
Shared Conference Room, Des Moines, Iowa**

FULL BOARD – PUBLIC SESSION^{3,4,5} - Shared Conference Room

Chair Siroos Shirazi, M.D., Vice Chair Jeffrey Snyder, M.D., Secretary Colleen Stockdale, M.D., Diane Clark, Tom Drew, Analisa Haberman, D.O., Greg Hoversten, D.O., Amber Mian, Hamed Tewfik, M.D., Joyce Vista-Wayne, M.D.

- A. Approval of Agenda and Acknowledgement of Absent Board Members**
- B. Approval of Minutes**
 - 1) Open Board Meeting Minutes for July 28-29, 2011**
 - 2) Open Board Meeting Minutes for June 2-3, 2011**
 - 3) Closed Board Meeting Minutes for April 7-8, 2011**
 - 4) Teleconference Meeting Minutes for August 25, 2011**
 - 5) Teleconference Meeting Minutes for June 30, 2011**
- C. Opportunity for Public Comments^{4,5}**
- D. Chair's Report**
- E. Executive Director's Report**
- F. Administrative Rules**
 - For consideration to notice and file*
 - 1. Amend 653 IAC Chapter 25, Contested Case Proceedings**
- G. Annual review of Board fees**
- H. Alternate Member**
 - 1. Proposed appointment of Paul Thurlow, Dubuque**
- I. Ad Hoc Board Committee**
 - 1. Review of 653 IAC Chapter 24, Complaints and Investigations**
- J. Legal Update**
 - 1. Court cases**
 - 2. Conflict of interest**
 - 3. Mandatory reporting of potential crimes –Iowa Code Chapter 272C.6(4)(a)**
 - 4. Training for investigators**
- K. Enforcement & Monitoring Update**
 - 1. Monitoring staff**
 - 2. Investigator certification**

- L. **Licensure Update**
 - 1. **FSMB uniform application users group meeting 9/13/11**
 - 2. **FSMB maintenance of licensure pilot project**
 - 3. **ARRA Licensure Portability Grant Project**
 - 4. **State Board Advisory Panel to the USMLE**
 - 5. **Licensure Committee Report³**

- M. **Iowa Physician Health Committee**
 - 1. **Program statistics**
 - 2. **Consideration of reappointment of Julie Scheib, Spirit Lake**
 - 3. **Board-Committee luncheon 10/14/11**

- N. **FYI/Articles**
 - 1. **Physician Reentry into Clinical Practice, Journal of Medical Regulation, Volume 97, Issue No. 1, 2011**
 - 2. **Addiction Now Defined As Brain Disorder, Not Behavior Problem, Live Science Staff, livescience.com, Psychological Disorders 2011 Live Science.Com, 8/15/11**
 - 3. **1 in 5 malpractice cases leads to a payout, Mike Stobbe, Associated Press, 8/18/11**

FULL BOARD – CLOSED SESSION¹ - Shared Conference Room

Shirazi*, Clark, Drew, Haberman, Hoversten, Mian, Snyder, Stockdale, Tewfik, Vista-Wayne

Friday, September 23, 2011

8:00 a.m. FULL BOARD – CLOSED SESSION¹ - Shared Conference Room

Shirazi*, Clark, Drew, Haberman, Hoversten, Mian, Snyder, Stockdale, Tewfik, Vista-Wayne

LUNCH BREAK

FULL BOARD – CLOSED SESSION¹ - Shared Conference Room

Shirazi*, Clark, Drew, Haberman, Hoversten, Mian, Snyder, Stockdale, Tewfik, Vista-Wayne

FULL BOARD - OPEN SESSION⁴ - Shared Conference Room

Shirazi*, Clark, Drew, Haberman, Hoversten, Mian, Snyder, Stockdale, Tewfik, Vista-Wayne

(1) The confidential matters listed on the agenda may concern medical records on the condition, diagnosis, care or treatment of a patient or investigation reports and other investigative information which are privileged and confidential under the provisions of Sections 22.7(2) and 272C.6(4), of the 2010 Code of Iowa. These matters constitute a sufficient basis for the Board to consider a closed session under the provisions of Section 21.5(1)(a), (d), (f) and (g) of the 2010 Code of Iowa. These sections provide that a governmental body may hold a closed session only by affirmative public vote of either two-thirds of the members of the body if all present, or all of the members present if not all members are present at the meeting to review or discuss records which are required or authorized by state or federal law to be kept confidential, to discuss whether to initiate licensee disciplinary investigations or proceedings and to discuss the decision to be rendered in a contested case conducted according to the provisions of Chapter 17A.

(2) Hearings may be closed at the discretion of the licensee, according to Section 272C.6(1) of the Code of Iowa 2010.

(3) Public agenda materials are available via e-mail. Public sessions are recorded and available via CD upon request. Contact teena.turnbaugh@iowa.gov.

(4) The Iowa Board of Medicine may address agenda items out of sequence to accommodate persons appearing before the Board or to aid in the efficiency or effectiveness of the meeting.'

*(5) At this time, members of the audience may address the Board for a period not to exceed 5 minutes. The Board reserves the right to reduce this time based on the number wishing to speak. If a member of the public wishes to address the Board with the intention of getting a Board decision at the meeting, the individual should request permission to be on the Board agenda. Written requests are due in the Board office at least 14 days in advance of the meeting. The next scheduled Board meeting is **Thursday and Friday, November 17-18, 2011, at the Iowa Board of Medicine, 400 SW 8th, Suite C, Des Moines, Iowa.***

If you require the assistance of auxiliary aids or services to participate in/or attend the meeting because of a disability, please call our ADA Coordinator at (515) 281-5604. If you are hearing impaired, call Relay IA TTY at 1-800-735-2942.

IOWA BOARD OF MEDICINE

PUBLIC OPEN HOUSE 2 TO 3 P.M. THURSDAY, SEPTEMBER 22

400 SW EIGHTH STREET, SUITE C, DES MOINES, IOWA 50309

Please join us for an open house from 2 to 3 p.m. Thursday, September 22, to celebrate the Board of Medicine's 125th anniversary. We'll have refreshments and displays of historical items. There will be a brief program at 2:15 p.m. A public meeting of the Board will follow at 3 p.m.





Executive Director's Report

(Prepared September 16, 2011, for the September 22-23, 2011, Board meeting)

PERSONNEL: The application process is under way for the vacant positions of investigator (enforcement), clerk-specialist (licensure), and secretary 1 (licensure). Mary Knapp was named to the new position of monitoring case manager. Mary has been a case manager for the Iowa Physician Health Program for the past three years. We are seeking authorization to hire a person to fill the position (program planner 2) Mary vacated.

REMODEL UPDATE: Medicine, Dental, Pharmacy and Nursing licensing boards in the RiverPoint Office Park will expand the size of the shared conference room to improve the set up/arrangement of tables for administrative case hearings and to provide more room for public seating at board meetings and hearings. The conference room will be enlarged by expanding into adjoining areas, including the Board's on-site storage room and the Pharmacy board's conference room. The Department of Administrative Services handles the contracts and arrangements. The project will be posted for bids on Sept. 19.

DATABASE: Significant progress has been made recently toward the completion of the database project. Conversion of data from the old system was completed in August, and testing will begin soon for the public portal, which is the web services portion of this project. The vendor has been assigned additional work to develop more reports from the new system.

TRAINING: Public member Diane Clark, Lake Mills, will attend the Citizen Advocacy Center training Oct. 20-21 in Washington, D.C. The agenda includes a review of regulatory board disciplinary programs, with a focus on how complaints are processed and how complainants are informed. Kent Nebel, director of legal affairs, will attend the Federation of State Medical Boards' attorney workshop Nov. 9-10, in Miami. The agenda includes an update of federal healthcare reform, pain management regulations, prescription drug monitoring programs, social media and the implications of social networking, discovery in administrative proceedings, and

EXECUTIVE DIRECTOR'S REPORT

September 22, 2011, Board meeting

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standard of care trial tactics. Assistant Attorney General Theresa Weeg, who counsels the Board of Medicine, will be a presenter at this workshop. Mark Bowden, executive director, completed the Administrators in Medicine's certified medical board executive director's training in Washington, D.C., August 26-29. This training was paid by AIM and the FSMB. Deb Anglin, physician health program coordinator, visited the Hazelden treatment center in Center City, MN, Aug. 14-16. She participated in parts of the treatment process, including a multidisciplinary staffing, bio-feedback and meditation sessions, lectures, etc. Some of the PHP participants have sought treatment at Hazelden. Board investigators Aaron Kephart, James Machamer, David McGlaughlin and David Schultz are attending the AIM-FSMB certified board investigator training Sept. 21-23 in Columbus, Ohio.

IOWA PRESCRIPTION ABUSE REDUCTION TASK FORCE: Mark Bowden, executive director, has represented the Board at two meetings of the Iowa Prescription Abuse Reduction Task Force established by the Governor's Office of Drug Control Policy. At the task force's meeting Sept. 13, there was considerable discussion on the role of law enforcement in cases of doctor-shopping, prescription forgery, and diversion of patients' pain medications. The goal of the task force is to recommend steps to reduce prescription drug abuse and diversion. The 42-member task force's final meeting is Oct. 11 and its recommendations will be considered by the Office in presenting an Iowa Prescription Abuse Reduction plan later this year.

OCTOBER-NOVEMBER CALENDAR

Hearings

(Updated 9/16/2011. Subject to settlements, delays or continuances.)

October 20 – Paul Quentzel, M.D., Sukhdarshan Bedi, M.D., Tyson Cobb, M.D., Roger Hansen, D.O., Michael Moeller, M.D.

Meetings

October 13 – Board teleconference meeting

October 14 – Iowa Physician Health Committee

November 17-18 – Board meeting in Des Moines

Office Holiday Closings

November 11 – Veterans Day

November 24-25 – Thanksgiving

MEDICINE BOARD[653]

Notice of Intended Action

Twenty-five interested persons, a governmental subdivision, an agency or association of 25 or more persons may demand an oral presentation hereon as provided in Iowa Code section 17A.4(1)“b.”

Notice is also given to the public that the Administrative Rules Review Committee may, on its own motion or on written request by any individual or group, review this proposed action under section 17A.8(6) at a regular or special meeting where the public or interested persons may be heard.

Pursuant to the authority of Iowa Code sections 147.76 and 272C.5, the Board of Medicine hereby proposes to amend Chapter 25, “Contested Case Proceedings,” Iowa Administrative Code.

The purpose of Chapter 25 is to provide rules for the administration of contested cases before the board. The proposed amendments require hearing panels have six members and allow parties in contested cases before the board to present the testimony of witnesses by affidavit, by written or video deposition, in person, by telephone, or by videoconference.

The Board approved this Notice of Intended Action during a regularly scheduled meeting on
XXXXXXXXXX.

After analysis and review of this proposed rule-making, no impact on jobs has been found.

Any interested person may present written comments on the proposed amendments not later than 4:30 p.m. on XXXXXX, XX, 2011. Such written materials should be sent to Mark Bowden, Executive Director, Board of Medicine, 400 S.W. Eighth Street, Suite C, Des Moines, Iowa 50309-4686; or sent by E-mail to mark.bowden@iowa.gov.

There will be a public hearing on XXXXXX XX, 2011, at X p.m. in the Board office, at which time persons may present their views either orally or in writing. The Board office is located at 400 S.W. Eighth Street, Suite C, Des Moines, Iowa.

The amendments are intended to implement Iowa Code chapter 272C.

The following amendments are proposed.

Item 1. Amend 653— 25.18(1) as follows:

~~A hearing may be~~ Hearings are conducted before a quorum of the board ~~or a panel of not less than three members of the board, at least two of whom are licensed by the board.~~ When a sufficient number of board members is unavailable to hear a contested case, the executive director, or the executive director's designee, may request alternate members, as defined in rule 653—1.1(17A,147) and Iowa Code sections 148.2A and 148.7(4), to serve on the hearing panel. A hearing panel containing alternate members must include at least six people, of whom ~~the majority shall be members licensed to practice under Iowa Code chapter 148.~~ a majority must be Board members, a majority must be members licensed to practice medicine under Iowa Code chapter 148, and no more than three may be public members.

Item 2. Amend 653— 25.18(6) as follows:

Subject to terms and conditions prescribed by the presiding officer, parties have the right to introduce evidence on issues of material fact, cross-examine witnesses present at the hearing as necessary for a full and true disclosure of the facts, present evidence in rebuttal, and submit briefs and engage in oral argument. Parties may present the testimony of witnesses by affidavit, by written or video deposition, in person, by telephone, or by videoconference.



September 22, 2011

TO: Members of the Iowa Board of Medicine
FR: Mark Bowden, Executive Director
RE: Annual review of Board fees

The Code of Iowa 147.80 requires that the Board of Medicine “shall annually review and adjust its schedule of fees so that, as nearly as possible, projected revenues equal projected costs and any imbalance in revenues and costs in a fiscal year is offset in a subsequent fiscal year.”

The Board’s revenue for fiscal year 2011 (ending June 30, 2011) was \$3,466,798.29. Expenditures were \$2,157,285.95.

The Board carried forward \$1,309,512.34 into fiscal year 2012 (beginning July 1, 2011). This is the result of funds collected, but unspent, for the Board’s new database, spending restrictions, i.e., out of state travel, some specialized training, purchasing of some items, and hiring restrictions, furlough days and wage freezes for exempt employees. By December 31, 2011, the Board is expected to be fully staffed (all four vacant positions filled) and the board’s obligations met for remodeling and data base expenses. Staff is projecting that this rollover will be reduced to \$400,000 at the start of the 2013 fiscal year (beginning July 1, 2012), and reduced to \$200,000 at the start of the 2014 fiscal year (beginning July 1, 2013).

After careful review of the Board of Medicine’s projected expenses for the remainder of fiscal year 2012 (July 1, 2011 through June 30, 2012), and for fiscal year 2013 (July 1, 2012 through June 30, 2013), Board staff is not recommending a change at this time for the Board’s schedule of fees for licensure and services. The Board raised fees in 2007 primarily to cover the database project. At that time, it was projected that fees would need to be increased in FY 2012. It now appears that fees may not need to be increased until FY 2014.



MARK BOWDEN
 Executive Director

Physician Licensure Fees

Application Fees	
<i>Permanent License (\$450/application, \$55/background check)</i>	\$505.00
<i>Resident License (\$150/application, \$55/background check)</i>	\$205.00
<i>Special License (\$300/application, \$55/background check)</i>	\$355.00
<i>Temporary License (\$100/application, \$55/background check)</i>	\$155.00

Renewal Fees	
Permanent License (2 Year) Via Paper Application	\$550.00
Online Renewal of Permanent License Only (2 Year)	\$450.00
Resident Extension	\$25.00
Special License (1Year)	\$200.00
Temporary License	\$50.00
Late Fee for Each Month of Grace Period (Permanent License)	\$100.00
Late Fee for Resident License	\$50.00
Inactive Fee (to place license in inactive status)	\$0.00

Verification Fees	
Certified License Verification to Other State Medical Boards for Permanent, Resident, Special, Temporary, per request (This type is required by all State Medical Boards)	\$40.00
Non-Certified License Verification for Permanent, Resident, Special, Temporary	\$15.00
Certified Statement of Exam Scores	\$45.00
Certified Statement of Exam Including History or Additional Documents	\$55.00

Reactivation of Application Fees	
Permanent License	\$150.00
Reinstatement	\$150.00

Reinstatement Fees	
Reinstatement of Inactive License (Under 12 months) for permanent licenses	\$550.00
Reinstatement of Inactive License (Over 12 months) for permanent licenses (\$500/application, \$55/background check)	\$555.00

Duplicate Fee

Duplicate Wall Certificate or Renewal Card (all license types)	\$25.00

Acupuncture Licensure Fees**Acupuncture Fees**

Acupuncture License (\$300/application; \$55 background check)	\$355.00
Acupuncture Renewal (2 Year)	\$300.00
Inactive Fee (to place license in inactive status)	\$0.00
Late Fee for Each Month of Grace Period (up to January 1st)	\$50.00
Reactivation of an Acupuncture Licensure Application	\$25.00
Reinstatement of an Inactive Acupuncture License	\$300.00
Certified Acupuncture License Verification to Another State Licensing Board	\$25.00
Non-Certified Acupuncture License Verification	\$20.00
Duplicate Wall Certificate or Renewal Card	\$25.00

Public Record Fees**Public Record**

Copy of Public Records	\$.25 per page plus labor
Labor in Excess of One-Quarter Hour	\$16 per hour
Electronic Copy of Public Record Delivered by Email	\$.10 per page/\$5.00 minimum
Labor for Electronic Copies	\$16 per hour
Electronic Files - Annual Subscription or prorated portion thereof, based on calendar year	\$24 per year
Printed Copies of Public Records - Annual Subscription or prorated portion thereof, based on calendar year	\$192 per year
Data List in Electronic File (all licensees)	\$50.00

Miscellaneous Fees**Item**

Copy of Application	\$20.00
Copy of Administrative Rules	\$10.00
Returned Checks	\$25.00
Board-ordered monitoring fee (per quarter)	\$100.00



September 22, 2011

RE: Paul Thurlow, proposed for appointment as an Alternate Member

Paul Thurlow of Dubuque served as a public member of the Board of Medicine. He was appointed to the Board in 2004 and 2008, and left the Board when his term expired on April 30, 2011. He served on the Board's Licensure and Screening committees and served on numerous panels to hear contested case hearings.

Iowa Code Chapter 148.2A Board of Medicine - Alternate Members

1. As used in this chapter, "board" means the board of medicine established in chapter 147.
2. Notwithstanding sections 17A.11, 69.16, 69.16A, 147.12, 147.14, and 147.19, the board may have a pool of up to ten alternate members, including members licensed to practice under this chapter and members not licensed to practice under this chapter, to substitute for board members who are disqualified or become unavailable for any other reason for contested case hearings.
 - a. The board may recommend, subject to approval by the governor, up to ten people to serve in a pool of alternate members.
 - b. A person serves in the pool of alternate members at the discretion of the board; however, the length of time an alternate member may serve in the pool shall not exceed nine years. A person who serves as an alternate member may later be appointed to the board and may serve nine years, in accordance with sections 147.12 and 147.19. A former board member may serve in the pool of alternate members.
 - c. An alternate member licensed under this chapter shall hold an active license and shall have been actively engaged in the practice of medicine and surgery or osteopathic medicine and surgery in the preceding three years, with the two most recent years of practice being in Iowa.
 - d. When a sufficient number of board members are unavailable to hear a contested case, the board may request alternate members to serve.
 - e. Notwithstanding section 17A.11, section 147.14, subsection 2, and section 272C.6, subsection 5:
 - (1) An alternate member is deemed a member of the board only for the hearing panel for which the alternate member serves.
 - (2) A hearing panel containing alternate members must include at least six people.
 - (3) The majority of a hearing panel containing alternate members shall be members of the board.
 - (4) The majority of a hearing panel containing alternate members shall be licensed to practice under this chapter.
 - (5) A decision of a hearing panel containing alternate members is considered a final decision of the board.
 - f. An alternate member shall not receive compensation in excess of that authorized by law for a board member.

272C.6 Hearings — power of subpoena — decisions.

1. Disciplinary hearings held pursuant to this chapter shall be heard by the board sitting as the hearing panel, or by a panel of not less than three board members who are licensed in the profession, or by a panel of not less than three members appointed pursuant to subsection 2. Notwithstanding chapters 17A and 21 a disciplinary hearing shall be open to the public at the discretion of the licensee.

2. When, in the opinion of a majority of the board, it is desirable to obtain specialists within an area of practice of a profession when holding disciplinary hearings, a licensing board may appoint licensees not having a conflict of interest to make findings of fact and to report to the board. Such findings shall not include any recommendation for or against licensee discipline.

3. *a.* The presiding officer of a hearing panel may issue subpoenas pursuant to rules of the board on behalf of the board or on behalf of the licensee. A licensee may have subpoenas issued on the licensee's behalf.

(1) A subpoena issued under the authority of a licensing board may compel the attendance of witnesses and the production of professional records, books, papers, correspondence and other records, whether or not privileged or confidential under law, which are deemed necessary as evidence in connection with a disciplinary proceeding.

(2) Nothing in this subsection shall be deemed to enable a licensing board to compel an attorney of the licensee, or stenographer or confidential clerk of the attorney, to disclose any information when privileged against disclosure by section 622.10.

(3) In the event of a refusal to obey a subpoena, the licensing board may petition the district court for its enforcement. Upon proper showing, the district court shall order the person to obey the subpoena, and if the person fails to obey the order of the court the person may be found guilty of contempt of court.

b. The presiding officer of a hearing panel may also administer oaths and affirmations, take or order that depositions be taken, and pursuant to rules of the board, grant immunity to a witness from disciplinary proceedings initiated either by the board or by other state agencies which might otherwise result from the testimony to be given by the witness to the panel.

4. *a.* In order to assure a free flow of information for accomplishing the purposes of this section, and notwithstanding section 622.10, all complaint files, investigation files, other investigation reports, and other investigative information in the possession of a licensing board or peer review committee acting under the authority of a licensing board or its employees or agents which relates to licensee discipline are privileged and confidential, and are not subject to discovery, subpoena, or other means of legal compulsion for their release to a person other than the licensee and the boards, their employees and agents involved in licensee discipline, and are not admissible in evidence in a judicial or administrative proceeding other than the proceeding involving licensee discipline. However, investigative information in the possession of a licensing board or its employees or agents which relates to licensee discipline may be disclosed to appropriate licensing authorities within this state, the appropriate licensing authority in another state, the coordinated licensure information system provided for in the nurse licensure compact contained in section 152E.1 or the advanced practice registered nurse compact contained in section 152E.3, the District of Columbia, or a territory or country in which the licensee is licensed or has applied for a license. If the investigative information in the possession of a licensing board or its employees or agents indicates a crime has been committed, the information shall be reported to the proper law enforcement agency. However, a final written decision and finding of fact of a licensing board in a disciplinary proceeding, including a decision referred to in section 272C.3, subsection 4, is a public record.

b. Pursuant to the provisions of section 17A.19, subsection 6, a licensing board upon an appeal by the licensee of the decision by the licensing board, shall transmit the entire record of the contested case to the reviewing court.

c. Notwithstanding the provisions of section 17A.19, subsection 6, if a waiver of privilege has been involuntary and evidence has been received at a disciplinary hearing, the court shall order withheld the identity of the individual whose privilege was waived.

5. Licensee discipline shall not be imposed except upon the affirmative vote of a majority of the licensing board.

6. *a.* A board created pursuant to chapter 147, 154A, 155, 169, 542, 542B, 543B, 543D, 544A, or 544B may charge a fee not to exceed seventy-five dollars for conducting a disciplinary hearing pursuant to this chapter which results in disciplinary action taken against the licensee by the board, and in addition to the fee, may recover from a licensee the costs for the following procedures and associated personnel:

(1) Transcript.

(2) Witness fees and expenses.

(3) Depositions.

(4) Medical examination fees incurred relating to a person licensed under chapter 147, 154A, 155, or 169.

b. The department of agriculture and land stewardship, the department of commerce, and the Iowa department of public health shall each adopt rules pursuant to chapter 17A which provide for the allocation of fees and costs collected pursuant to this section to the board under its jurisdiction collecting the fees and costs. The fees and costs shall be considered repayment receipts as defined in section 8.2.

[C79, 81, §258A.6; 82 Acts, ch 1005, §8]

86 Acts, ch 1211, §15; 92 Acts, ch 1125, §1

C93, §272C.6 2000 Acts, ch 1008, §13; 2001 Acts, ch 55, §29, 38; 2005

Acts, ch 53, §10; 2010 Acts, ch 1061, §94

Board of Medicine, see §148.2A, 148.7

Subsections 3, 4, and 6 amended

IPHP Statistical Report

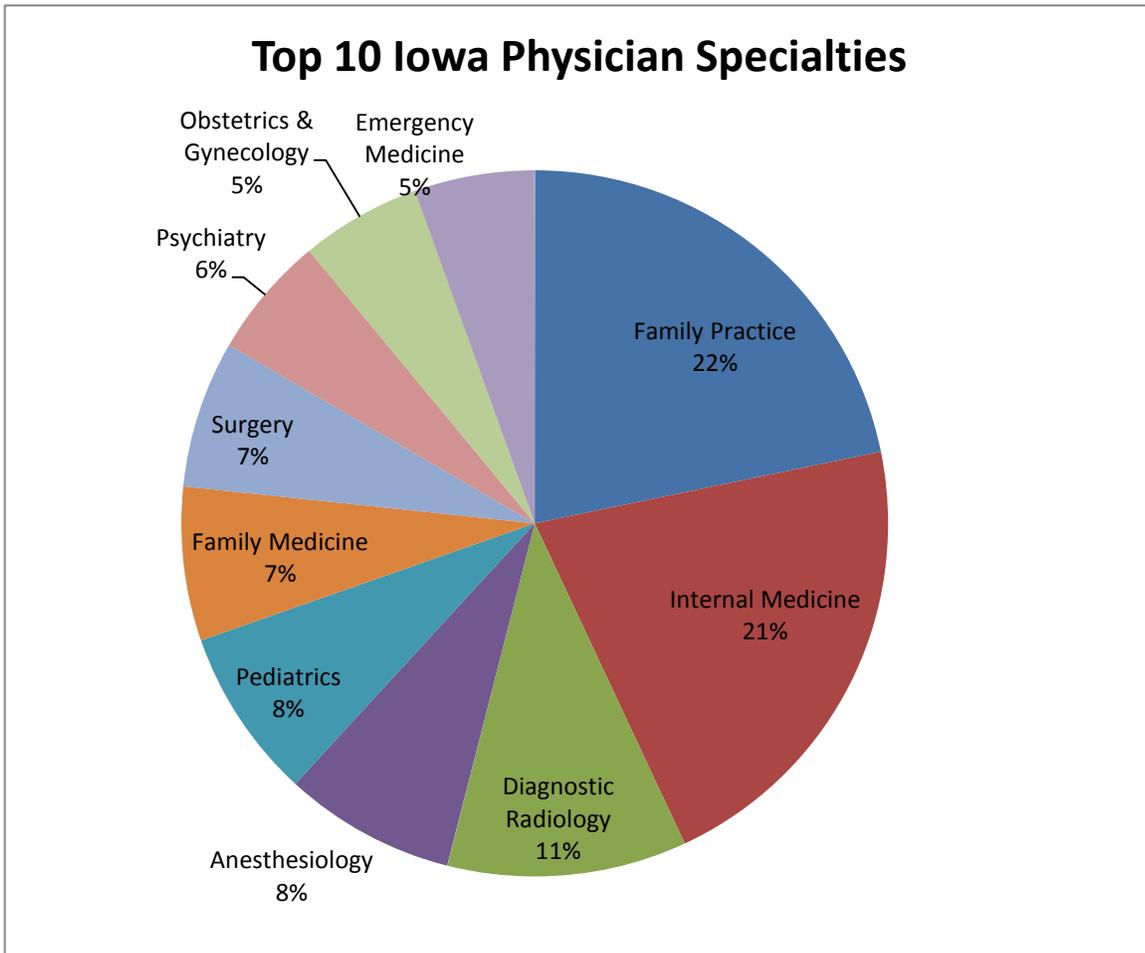
	8/10	10/10	12/10	2/11	4/11	6/11	7/11	9/11	11/11	12/31/11
# Participants	87	84	82	85	89	92	82	79		
Gender										
Male	69	67	67	70	74	77	72	70		
Female	18	17	15	15	15	15	10	9		
Avg Age	46.7	44	44.2	46.15	46.85			47		
Avg Length in IPHP (Years)	2.1	3.4	3.2	2.5	2.4			2.5		
Degree Type										
M.D.	69	67	65	66	69	72	62	59		
D.O.	18	17	17	19	20	20	20	20		
Specialty										
Anesthesia	3	6	6	6	5	7	7	7		
Card Surgery	1	1	1	1	1	1	1	1		
Derm	2	2	2	3	3	2	1	2		
Emer Med	2	2	3	4	4	5	4	4		
Family Practice	22	23	22	22	26	25	23	22		
Gen Practioner	3	4	4	3	2	2	2	2		
Internal Medicine	14	12	15	16	17	17	12	12		
Maxfac Surg	1	1	1	0	0	0	0	0		
Neurology	2	1	1	2	2	2	3	3		
Nuclear Med		1	1	1	1	1	1	1		
OB/GYN	3	6	2	6	7	7	8	8		
Oncology		1	6	2	0	1		0		
Ophthalmology		4	1	4	4	4	2	3		
Ortho Surgery	1	2	4	2	3	3	4	3		
Oto				1	2	1	1	0		
Pathology	1	1	2	1	1	1	1	0		
Pediatrics	2	2	1	3	3	3	3	3		
Psychiatry	2	3	1	3	4	4	3	2		
Pulmonary	1	0	2	0	0			0		
Radiology	2	1	2	1	1	2	2	1		
Surgery	1	3	0	4	3	3	2	3		
Urology	1	1	1	0	0			1		
Other Specialty	6	3	3			1	1	1		

IPHP Statistical Report

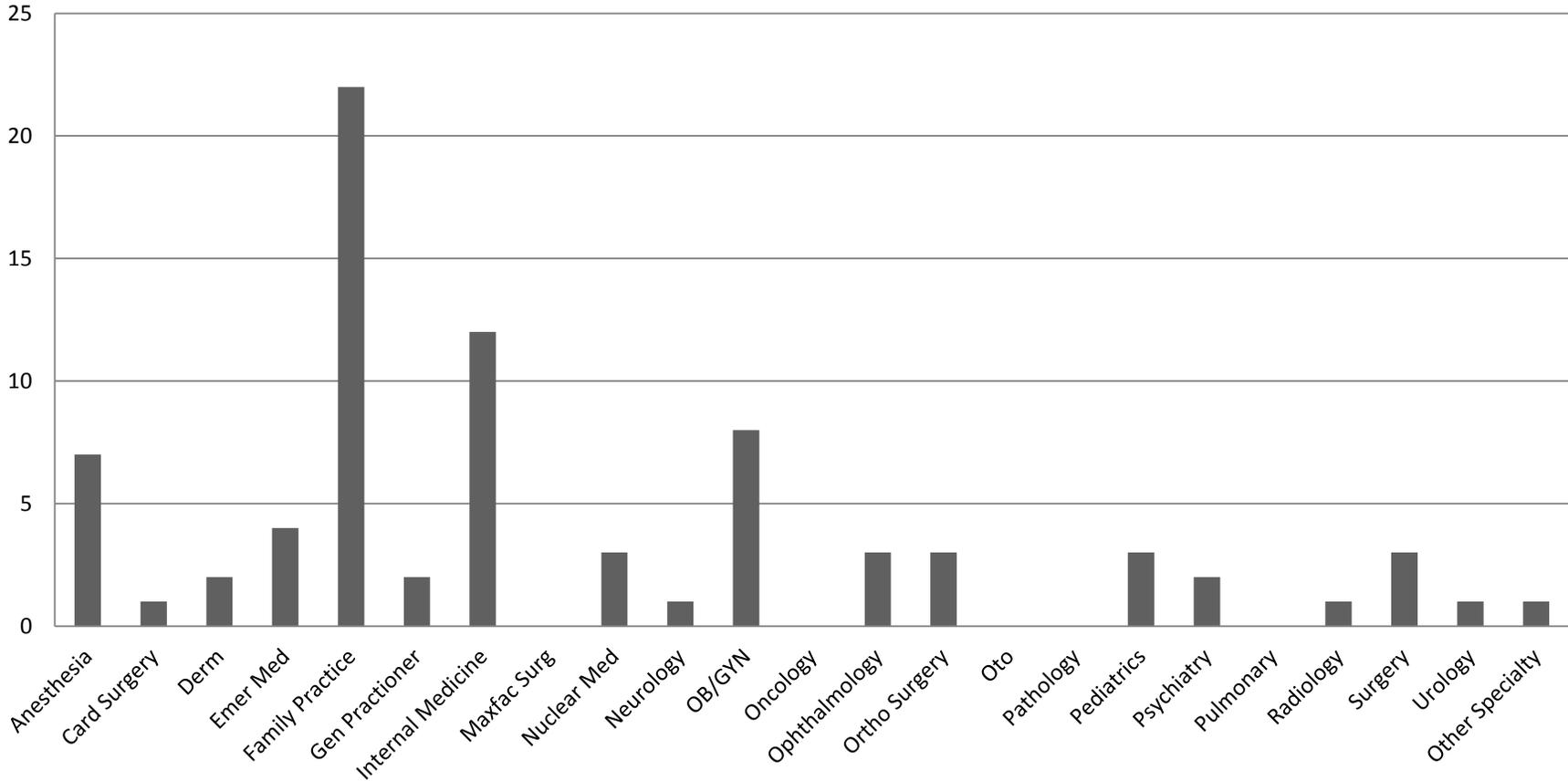
	8/10	10/10	12/10	2/11	4/11	6/11	7/11	9/11	11/11	12/31/11
Under Contract	69	74	76	77	76	73	38	65		
Type of Case										
Chemica Dependency	21	19	22	23	21	20	11	17		
Dual Dx	21	27	26	26	24	23	16	19		
Mental Health	25	25	24	24	24	25	9	11		
Physical Disability	5	6	4	5	5	6	2	6		
Physical Disability+MH								1		
New Participants YTD	23	27	32	4	14	20	31	36		
Referral Source										
Self	47	48	47	2	8	11	13	13		
Licensure	22	22	20	2	2	5	12	17		
Board	7	5	5				1	1		
CRC		0								
Enf	10	10	10		4	4	5	5		
Discharged YTD	19	22	21	3	10	12	27	42		
Type of Discharge YTD										
Successful	14	15	15		3	3	9	18		
Nullified Contract		0	0		3	2	3	4		
Surrendered		0	0							
Inactive	1	2	2	1	1	1	4	4		
Board Order		0	0							
No Impairment	4	4	4	1	3	3	9	13		
Other		0	0			3	1	3		
Noticed to IBM YTD	5	5	9		3	3	3	5		
Relapse YTD	3	3	5		1	1	1	1		
Out of State PHP	7	7	8	8	9	9	8	5		

Top 10 Iowa Physician Specialties

Family Practice	1524
Internal Medicine	1491
Diagnostic Radiology	768
Anesthesiology	549
Pediatrics	548
Family Medicine	493
Surgery	472
Psychiatry	392
Obstetrics & Gynecology	386
Emergency Medicine	385



IPHP Participants by Specialty



IPHP
Iowa Physician Health Program
www.iphp.iowa.gov

9/14/11

Memorandum

To: Iowa Board of Medicine

From: Deb Anglin

Regarding: Julie Scheib, BLS, ACADC

Julie Scheib is nearing the end of her first 3 year term on the IPHC. Ms. Scheib has proven herself to be a valuable member of the IPHC by consistently attending meetings, being well prepared, and providing support and guidance to participants. She has graciously agreed to serve another 3 year term with the approval of the Board.

Iowa Administrative Code 653 Chapter 14.4 Organization of the Iowa Physician Health Committee.

The board shall appoint the members of the IPHC.

14.4(1) Membership. The membership of the IPHC includes, but is not limited to:

- a* The executive director of the board or the director's designee from the board's staff;
- b* One physician who has remained free of addiction for a period of no less than two years following successful completion of a board-approved recovery program, a board-ordered probation for alcohol or drug abuse, dependency, or addiction, or an IPHC contract;
- c* One practitioner with expertise in substance abuse/addiction treatment programs;
- d* One psychiatrist; and
- e* One public member.

14.4(2) Officers. The committee shall elect a chairperson and vice chairperson at the last meeting of each calendar year to begin serving a one-year term on January 1.

14.4(3) Terms. Committee members, except the executive director, shall be appointed for three-year terms, for a maximum of three terms. Terms shall expire on December 31 of the third year of the term.

Physician Reentry into Clinical Practice: Regulatory Challenges

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

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

Introduction

Physician reentry is defined by the American Medical Association as: "A return to clinical practice in the discipline in which one has been trained or certified following an extended period of clinical inactivity not resulting from discipline or impairment."¹ Reentering physicians leave clinical practice voluntarily and as such are distinct from remediating physicians, who have demonstrated deficiencies in physician performance. Further, reentering physicians return to the field of practice which they left and, thus, are different from physicians who are retraining in order to move into a new area of clinical practice.¹ Physician reentry is a concept that may be poorly understood by many practitioners.

A number of factors are driving a new emphasis on lifelong evidence of physician competence and assessment of performance in medical practice.

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

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

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

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

This paper addresses that need by (1) presenting survey data on current physician reentry 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.³ Physicians may expect to take time away from practice at some point during

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.

their careers for reasons that include family leave (maternity/paternity leave, child rearing); caretaking and personal-relationships issues; health issues; career dissatisfaction; pursuit of alternate careers, such as administration or military service; and humanitarian leave.⁴⁻⁷

Physicians may seek reentry to clinical practice for a variety of reasons. Often they return when their need to care for family is no longer pressing or when they have overcome a health issue. Some physicians return because they miss the practice of medicine, have financial needs, want a new

challenge, wish to help fulfill community needs or simply have too much free time.⁷

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

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

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

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

The three components of MOL are: (1) reflective self assessment; (2) assessment of knowledge and skills; and (3) performance in practice.¹¹⁻¹² Of particular relevance to physician reentry is component 3, performance in practice, which states that “physicians

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.

must demonstrate accountability for performance in their practice using a variety of methods that incorporate reference data to assess their performance in practice and guide improvement.”¹² This component of the proposed framework for MOL indicates that physicians must have ongoing involvement in patient care—a difficult, if not impossible, requirement for reentering physicians.

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

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

The AMA annually publishes the *State Medical Licensure Requirements and Statistics*, which is based on a survey that includes questions on

physician reentry policy. The most recent survey was sent to 64 State Boards of Allopathic and Osteopathic Medical Examiners in the U.S.; medical boards in U.S. territories were excluded. Fifty-nine of the 64 medical boards responded to the survey, for a response rate of 92 percent.

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

Physician reentry policy

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

Length of time out of practice

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

Patient care requirements for relicensure

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

Data collection on reentry

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

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

Discussion

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

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

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

Literature intended to inform the decisions by medical licensing boards of when reentering physicians should receive additional education and training

may add further confusion. Findings from a study of the relationship between the volume of procedures practiced by physicians and medical outcomes show that the less a procedure is practiced, the greater the likelihood of complication.¹⁵ In a systematic review of the medical literature to study the relationship between experience in caring for patients and performance quality, it was concluded that physicians who have been in practice longer have less factual knowledge than their less-experienced counterparts even after adjusting for patient volume.¹⁶

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

While not all physicians may need to update their skills before reentering practice, the current structure of the licensure system may be preventing medical regulatory bodies from making that assessment. Studies are needed on how time spent away from clinical practice affects the clinical skills of physicians and, ultimately, the quality of care. In addition to

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.

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

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

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.

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:

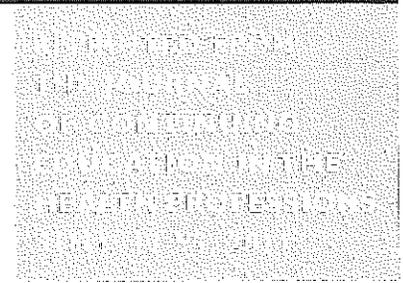
- A site (medical school, graduate medical education program, teaching hospital and medical home, as well as non-traditional sites such as mental health hospitals and nursing homes) that provides reentering physicians with opportunities for supervised clinical practice in their previous clinical fields;
 - 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

Introduction

The American Medical Association (AMA) suggests that fewer than 10 percent of physicians were on inactive status in 2003;¹ this number rose to nearly 12 percent in 2007.² 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.^{3,4}

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,^{5,6} 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),⁷ 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 survey⁸ reported that they have a policy regarding physician reentry; an additional nine boards are in the process of developing a policy.⁸ 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,⁸ 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.⁸ 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 1978.⁹ 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).¹⁰ Two studies about retraining such physicians were published in 1969 and 1972.^{11,12} A resurgence of interest in physician reentry surfaced in the early 2000s, as indicated by a flurry of both scientific and lay press articles.^{3,13,14} 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.¹⁵ 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

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.

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.⁵ 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^{16,17} and that traditional continuing medical education conferences alone may not be effective in improving practice.¹⁸ This approach is consistent with that of remediation programs both in the United States and internationally.^{17,19} 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
Total	25	37	62	

*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
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.

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 1982.¹⁰

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).²⁰ 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
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.

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.^{19, 21-23} 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.²⁴ 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.²⁵ 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,^{26,27} 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.⁸

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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Addiction Now Defined As Brain Disorder, Not Behavior Problem



LiveScience Staff

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Addiction is a chronic brain disorder and not simply a behavior problem involving alcohol, drugs, gambling or sex, experts contend in a new definition of addiction, one that is not solely related to problematic substance abuse.

The American Society of Addiction Medicine (ASAM) just released this new definition of addiction after a four-year process involving more than 80 experts.

"At its core, addiction isn't just a social problem or a moral problem or a criminal problem. It's a brain problem whose behaviors manifest in all these other areas," said Dr. Michael Miller, past president of ASAM who oversaw the development of the new definition. "Many [behaviors driven by addiction](#) are real problems and sometimes criminal acts. But the disease is about brains, not drugs. It's about underlying neurology, not outward actions."

The new definition also describes addiction as a primary disease, meaning that it's not the result of other causes, such as emotional or [psychiatric problems](#). And like cardiovascular disease and diabetes, addiction is recognized as a chronic disease; so it must be treated, managed and monitored over a person's lifetime, the researchers say.

Two decades of advancements in neuroscience convinced ASAM officials that addiction should be redefined by what's going on in the brain. For instance, research has shown that addiction affects [the brain's reward circuitry](#), such that memories of previous experiences with food, sex, alcohol and other drugs trigger cravings and more addictive behaviors. Brain circuitry that governs impulse control and judgment is also altered in the brains of addicts, resulting in the nonsensical pursuit of "rewards," such as alcohol and other drugs.

A long-standing debate has roiled over whether addicts have a choice over their behaviors, said Dr. Raju Hajela, former president of the Canadian Society of Addiction Medicine and chair of the ASAM committee on addiction's new definition.

"The disease creates distortions in thinking, feelings and perceptions, which drive people to behave in ways that are not understandable to others around them," Hajela said in a statement. "Simply put, addiction is not a choice. [Addictive behaviors](#) are a manifestation of the disease, not a cause."

Even so, Hajela pointed out, choice does play a role in getting help.

"Because there is no pill which alone can cure addiction, choosing recovery over unhealthy behaviors is necessary," Hajela said.

This "choosing recovery" is akin to people with heart disease who may not choose the underlying genetic causes of their heart problems but do need to [choose to eat healthier](#) or begin exercising, in addition to medical or surgical interventions, the researchers said.

"So, we have to stop moralizing, blaming, controlling or smirking at the person with the disease of addiction, and start creating opportunities for individuals and families to get help and providing assistance in choosing proper treatment," Miller said.

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1 in 5 malpractice cases leads to a payout

By Mike Stobbe

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ATLANTA - Only 1 in 5 malpractice claims against doctors leads to a settlement or other payout, according to the most comprehensive study of these claims in two decades.

But while doctors and their insurers may be winning most of these challenges, that's still a lot of fighting. Each year about 1 in 14 doctors is the target of a claim, and most physicians and virtually every surgeon will face at least one in their careers, the study found.

Malpractice cases carry a significant emotional cost for doctors, said study coauthor Amitabh Chandra, an economist and professor of public policy at the Harvard Kennedy School of Government

"They hate having their name dragged through the local newspaper and having to go to court," he said.

The study might seem to support a common opinion among doctors that most malpractice lawsuits are baseless, but the authors said the truth was more complicated than that.

They noted influential earlier research in New York state concluding that just a tiny fraction of the patients harmed by medical mistakes actually file claims.

Trial lawyers say cost is a barrier to bringing a claim to court. There are very high up-front costs for hiring expert witnesses and preparing a case. Doctors, hospitals, and their insurers often have significant money and legal firepower. Some states also have caps on malpractice awards. So, usually, only very strong cases with high expected payouts are pursued.

Given the expense and other difficulties involved in winning, it's doubtful most claims are filed on a greedy whim, the researchers said.

"A lawyer would have to be an idiot to take a frivolous case to court," Chandra said.

The study was published online Wednesday (August 17) by the New England Journal of Medicine.

The research team turned to one of the nation's largest national malpractice insurers, analyzing data for about 41,000 physicians who bought coverage from 1991-2005. The researchers could get the data only by signing an agreement not to identify the insurer, so they wouldn't disclose the name of the company.

The insurer represents only about 3 percent of the nation's doctors, but it operates in all 50 states. The average payouts were about the same as seen in the government-created National Practitioner Data Bank, which records payouts but doesn't record all claims filed.

The study found:

- About 7.5 percent of doctors have a claim filed against them each year.
- Fewer than 2 percent of doctors each year were the subject of a successful claim, in which the insurer had to pay a settlement or court judgment.
- Some types of doctors were sued more than others. About 19 percent of neurosurgeons and heart surgeons every year were sued, making them the most targeted specialties. Pediatricians and psychiatrists were sued the least, with only about 3 percent of them every year facing a claim.
- When pediatricians did pay a claim, it was much more than other doctors. The average pediatric claim was more than \$520,000, while the average was about \$275,000.

"Jurors' hearts cry out for injured patients, especially when kids are involved," Chandra said. The amount attached to a pediatric case also rises because many more years of suffering are involved than if the victim is middle-aged or elderly, experts said.