
Facilitating Physician Relicensure and Reentry into Clinical Practice:

Collaboration between a State Medical Board and a Medical School

William F. Rayburn, MD, MBA; Amanda Quintana; Ellen Cosgrove, MD; and Grant La Farge, MD

ABSTRACT: This article summarizes results of a unique, 10-year collaboration between the New Mexico Medical Board and the University of New Mexico School of Medicine's mini-sabbatical program for physicians considering relicensure and reentry into practice. The Board assesses all physicians wishing to reenter active practice to determine their background and needs, and the medical school's office of continuing medical education then evaluates candidates for their retraining goals, coursework, and faculty involvement. Progress is measured weekly, at course completion, and three months thereafter. Of the 27 physicians referred from the Board between 2004 and 2014, five were judged to require more extensive residency retraining and four received administrative medical licenses. Twelve of the 18 eligible candidates elected to enter the medical school's mini-sabbatical program. The median training was four weeks (160 *AMA PRA Category 1 Credits*TM). Their education did not interfere with the learning of medical students and residents. All except one demonstrated acceptable core clinical skills to permit granting of an unrestricted medical license. Eleven completed the program and were successful in attaining employment in New Mexico. This collaboration permitted a determination for a physician about the extent of retraining before relicensure. The mini-sabbatical program was successful in returning eligible physicians to practice in our state.

Keywords: medical board, mini-sabbatical, reentry, relicensure

Introduction

There is a growing recognition among physician leaders of medical licensing and credentialing boards about the need to re-educate physicians who have not practiced medicine or seen patients for a minimum of two years and wish to return to practice.¹ The number of physicians desiring to reenter practice is unknown, yet data about these clinically inactive physicians suggest that the number could be significant. According to the American Medical Association (AMA), the percentage of inactive physicians doubled from 5.5% to 12.5% between 1980 and 2008.² Given these numbers and a looming shortage of physicians, most notably in primary care or in underserved areas, it is important to create effective processes for facilitating relicensure and reentry of competent physicians into practice.³

Physicians leave practice for many reasons, including retirement, illness, family obligations, military service, financial reasons, or license suspension or revocation. Upon seeking reentry with the need to relicensure, physicians face numerous challenges: meeting licensing and credentialing requirements; finding appropriate retraining programs; affording

the coursework; and overcoming impediments in completion of retraining.¹ Reducing barriers to relicensure into practice would represent a strategy for addressing a physician shortage.

An inactive physician's return to clinical practice can also be challenging for the state licensing board and any reeducation program. State licensing boards have varying reentry policy requirements, ranging from evidence of sufficient knowledge-base with baseline, on-going continuing medical education (CME) to completion of a formal refresher course.^{3,4} Few reentry training programs exist for many

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reasons: expenses for development and maintenance of coursework; sufficient numbers of trainees; clinical site and preceptor recruitment; faculty time and commitment; and staff resources.^{1,2}

New Mexico is a predominantly rural state with an established physician shortage. We consider our experience with physician relicensing before reentry into practice to be unique. The state university medical school and state medical board have

IN MOST CASES, THE CANDIDATE FOR RELICENSURE WAS SPONSORED BY A HOSPITAL OR HEALTH SYSTEM FOR THE COST OF RETRAINING OR WAS AWARE OF EMPLOYMENT OPPORTUNITIES ONCE THEIR TRAINING WAS COMPLETE.

worked together in assisting physicians wishing to explore whether or not to reenter into the state clinician workforce. The purpose of this study was to describe how these two institutions worked closely in facilitating physician relicensure and reentry into practice. Lessons gained from this 10-year relationship and the evolution of an innovative mini-sabbatical program will be described.

Methods

Evaluation for Retraining

Evaluation of a physician considering reentry into clinical practice and needing relicensure is a stepwise process which began at the New Mexico Medical Board. Any physician wishing to reenter active medical practice was encouraged to contact the Board office for an initial evaluation. The Board's medical director evaluated each physician's self-assessment, practice history, and length of time away from active practice to determine that individual's need for referral to the medical school's mini-sabbatical program.

The Board's responsibility was to assure a basic level of practice safety through current competency, including an up-to-date knowledge-base and clinical skills. The Board did not use SPEX or similar standardized testing in over 12 years, because it was too general to assess the knowledge base. Instead, knowledge was assessed by either sufficient relevant CME or course completion or recertification by their specialty board. Once either was assured, the physician was referred to the University of New Mexico School of Medicine for consideration of enrollment in a mini-sabbatical designed to assess and update clinical competence and current skills.

To be eligible for possible mini-sabbatical retraining, a physician had to meet the following eligibility criteria: 1) have an MD degree, 2) be out of practice for a minimum of two years, 3) demonstrate evidence of continuing medical education (75 or more credits for the immediate past three years, or recertification by an ABMS board), 4) not have forfeited their license due to a suspension or revocation, and 5) express the intention of practicing in New Mexico. Boards of allopathic and osteopathic medicine were separate, as in many states, so the eligibility of a DO physician was determined by the New Mexico Osteopathic Examiners Board. In most cases, the candidate for relicensure was sponsored by a hospital or health system for the cost of retraining or was aware of employment opportunities once their training was complete.

Upon notification from the Board about a potential candidate for retraining, the University of New Mexico Office of Continuing Medical Education and Professional Development evaluated the candidate for coursework development, continuity, and completion. The associate dean who oversaw the mini-sabbatical program arranged a meeting with the candidate. After the interview, the associate dean notified the Board about any concerns about the candidate before the Board's final decision.

If the candidate was deemed to be acceptable for entry into the program, the associate dean identified a dedicated preceptor(s) within the appropriate department who would be willing to mentor and provide training oversight. The preceptor was an experienced senior clinician in the specific specialty.

ANY PHYSICIAN WISHING TO REENTER ACTIVE MEDICAL PRACTICE WAS ENCOURAGED TO CONTACT THE BOARD OFFICE FOR AN INITIAL EVALUATION.

The Board then granted a training license to the candidate, permitting him or her to practice medicine under same coverage as a resident physician by the university's risk management insurance. Payment from the enrollee (or sponsor) was \$1,000 per week which was proportionately distributed (85/15) to the CME office and the clinical department.

Mini-Sabbatical Program

Important components of the returning physician's education included a self-paced review of current medical knowledge and an on-site assessment of

both knowledge and skills. There was no on-line training; instead, trainees participated in both inpatient and outpatient settings. Rounds, chart reviews, and core conferences were case-based and interactive. Case logs were kept to record a broad range of experiences. Trainees learned with several department members, including residents or fellows, nurse practitioners, and physician assistants.

Returning physicians, themselves, often identified their computer skills and evidence-based literature searches as areas of deficiency. The program offered information technology skills sessions and faculty-guided, evidence-based medicine teaching to strengthen computer and scholarly skills before graduation. Training in accessing electronic health records and writing medical notes for case logs were reviewed regularly with the physician's preceptor.

To ensure that trainees achieved their learning goals, the associate dean regularly sought the trainee's verbal feedback, and aided in adjusting schedules

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with the preceptor as necessary. Each trainee also met regularly with appropriate personnel (other faculty, advanced non-physician practitioners, residents) at the assigned preceptor's office, information center library, and skills laboratory as appropriate for individualized training. The associate dean met with either the trainee or preceptor weekly.

Evaluation of Training

Each mini-sabbatical course was designed to last 3 to 8 weeks (in most cases, four weeks) since this period was deemed by the Board and medical school to be reasonable for assessing progress. This period was extended if the associate dean, preceptor, or trainee considered the educational experience to be inadequate. The trainee received a certificate upon completion of the coursework. A letter generated by the associate dean listed the skill sets evaluated, conferences attended, and clinics or hospital rounds attended and summarized faculty feedback. The letter was used by the Board for eventual determination of the graduate's relicensure.

Unless the Board decided against relicensure, the training medical license was converted promptly to an unrestricted one which permitted independent care for patients. The license was to be renewed in the customary three-year cycle. If desired by the trainee, the Office of Continuing Medical Education and Professional Development would advocate on his or her behalf by writing letters or speaking to hospital committees and employers. Verbal feedback from the physician trainee was expected to be given to the CME Office at course completion and about three months later.

Results

Our 10-year experience with this stepwise process is summarized in Figure 1. Of the 43 physicians who inquired at the state medical board about re-entry, 10 decided against further consideration. Those physicians tended to be 55 years or older and be in surgical fields. Reasons against applying for the mini-sabbatical were older age, time commitment, cost, constraints in surgical volume, and uncertain plans. The remaining 33 decided in favor of pursuing retraining after consultation with the Board's medical director. Six were not approved by the Board for the mini-sabbatical, because they were considered by the associate dean and potential preceptor to require a longer period of retraining, such as a year or two in a residency program.

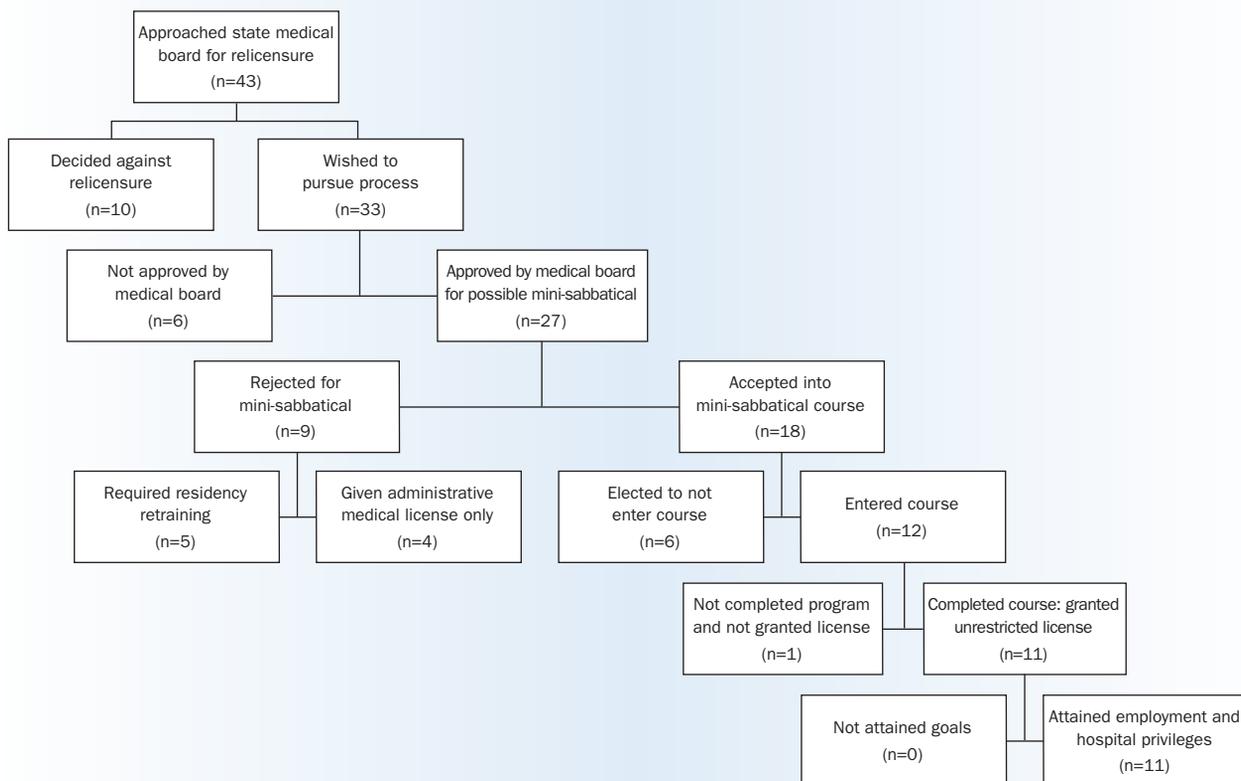
One-third of the remaining 27 physicians were referred from the Board but denied entry into the mini-sabbatical program. Primary reasons for that denial came from combined impressions by the associate dean and potential preceptor(s) that either (1) a mini-sabbatical would be an insufficient period or caseload to address that physician's learning needs and could interfere with resident

Table 1
Specialties of Physicians Seeking Relicensure and Reentry into Practice

| | Requesting relicensure | Relicensed and in practice |
|---------------------------|------------------------|----------------------------|
| General internal medicine | 13 | 5 |
| Family medicine | 11 | 4 |
| Surgery | 3 | 0 |
| Pediatrics | 1 | 1 |
| Psychiatry | 1 | 1 |
| Neurology | 1 | 0 |
| Emergency medicine | 1 | 0 |
| Radiology | 1 | 0 |
| Anesthesiology | 1 | 0 |
| Total | 33 | 11 |

Figure 1

Step-wise process of evaluating, training, and eventual relicensing of physicians considering reentry into clinical practice.



training (n=4), or (2) an administrative-only medical license was needed (n=5).

Eighteen candidates were accepted into the program, yet six declined to undertake the coursework due to time and cost constraints. Table 1 lists the number of physicians in each specialty who inquired at the medical board about step-wise re-entry and who completed the mini-sabbatical. The majority were 48 to 63 years old, similar in gender, and out of clinical practice for 2 to 13 years. Most that completed the coursework were general internists or family physicians, except for one psychiatrist and one pediatrician.

Eleven of the 12 candidates who undertook the mini-sabbatical were successful in completing their training. The median duration of the coursework was four weeks (range: three weeks to seven weeks) that was either continuous or divided into weekly or biweekly periods. The trainee's education did not appear to interfere with the medical student, resident, or fellow learning. Clinical decision-making by the trainee was encouraged, along with teaching of students or residents in the presence of a preceptor.

All 11 trainees received their unrestricted medical licenses and attained their goals. Each was offered a position in an outpatient setting and received privileging at their designated hospital in New Mexico. The median cost to the trainee (or sponsor) was \$4,000, with a median of 160 *AMA PRA Category 1 credits* (40 credits weekly) being granted. Verbal feedback from the trainee at the times of course completion and onset of employment were favorable and constructive for future trainees.

Discussion

Physicians considering relicensure and reentry into active medical practice face many challenges: acceptable health, licensing and credentialing requirements, competence in knowledge and clinical skills, and cost and geographic barriers of retraining programs.^{1,5} This report summarizes a 10-year collaboration between our state medical board and medical school physician refresher training program. This step-wise effort encouraged a dialogue between both institutions to advise a physician more realistically about relicensure requirements

and retraining options. The medical school mini-sabbatical program was especially helpful to the Board in determining the extent to which a physician needed to undergo retraining. When learning needs were tailored to qualifying candidates, the program was successful in returning those physicians to active practice in our state.

Like other training programs, the number of physicians considering reentry in the present study was very small during this period.^{1,2,5} This is likely explained by our including only those who needed to be relicensed. Furthermore, only one-fourth of those who originally expressed an interest in reentering practice graduated from our mini-sabbatical program. We cannot assume that this 25% rate is acceptable due to the uniqueness of this relation between the Board and medical school. What compelled them to return to practice was their interest in medicine and providing patient care. Each succeeded in achieving their goal usually within one month of the mini-sabbatical.

Certain limitations of our collaborative effort are worthy of mention. Physicians considering relicensure and reentry involved only a very small proportion of all unlicensed New Mexican physicians and may not represent the general characteristics of doctors.⁷ We had no experience with physicians who required maintenance of certification, since all were board-certified by either being grandfathered or maintaining documentation of appropriate CME credits. We had few non-primary care physicians to consider this retraining option, and did not maintain any records as to why other specialists did not pursue reentry into practice. Our experience did not include surgeons who required retraining in performing procedures. We also had no experience with disabled surgeons who were no longer able to practice their craft but were fully capable of diagnosing and treating patients in primary care settings. Tracking long-term outcomes of physician reentry programs is a challenge.^{1,5} We did not gain the graduate's perspectives beyond the first few weeks as to whether the mini-sabbatical prepared them well in returning long-term to clinical practice or whether they eventually moved and became licensed in that state.

Despite these limitations, our findings contribute to the limited reported experiences of reentry programs. The stepwise collaboration between our state medical board and medical school is unique, especially in requiring the physician to be competent to be relicensed and practice in our state. The mini-sabbatical program described here

provides physicians of diverse backgrounds; with contemporary tools needed to offer principally outpatient primary care. Upon graduation, the program participants received an average of 160 hours of AMA Category 1 CME credits from our medical school, which helps document their updated knowledge for today's patients. The long-term impact of this selective and innovative learning effort on a physicians' success with health care delivery, is a key area for further investigation. ■

About the Authors

William F. Rayburn, MD, MBA, is Associate Dean of Continuing Medical Education and Professional Development and Distinguished Professor and Emeritus Chair, Obstetrics and Gynecology, University of New Mexico School of Medicine, Albuquerque, NM.

Amanda Quintana is Public Information Officer and former Licensing Manager of the New Mexico Medical Board.

Ellen Cosgrove, MD, is Vice Dean for Academic Affairs and Education, University of Nevada School of Medicine, Las Vegas, NV and former Associate Dean of Education, University of New Mexico School of Medicine, Albuquerque, NM.

C. Grant La Farge, MD, is Medical Director of the New Mexico Medical Board.

Note

The information in this article was presented at the 11th Annual Association of American Medical Colleges Health Workforce Research Conference, Alexandria, VA, April 30, 2015.

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