

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 312  
(A-24)

Introduced by: Georgia

Subject: AMA Collaboration with FSMB to Assist in Licensing Reentrant Physicians

Referred to: Reference Committee C

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1 Whereas, physicians take time out of continuous practice for a variety of reasons, such as for  
2 mental or physical health issues, family or personal life events; and  
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4 Whereas, such time off from practice raises questions about a physician's fitness to return to  
5 active practice; and  
6  
7 Whereas, state medical boards are charged with protecting the public and must evaluate  
8 physicians wishing to return to practice to determine their readiness to practice in a safe and  
9 competent manner; and  
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11 Whereas, the Federation of State Medical Boards (FSMB) established the Workgroup on  
12 Reentry in 2023 to evaluate and revise its existing policies on physician reentry to practice; and  
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14 Whereas, the FSMB Workgroup on Reentry found a paucity of research to support  
15 development of reentry policies, procedures, and resources for state medical boards; and  
16  
17 Whereas, a survey of state medical boards found that only 57% have a policy or formal process  
18 for the evaluation or retraining for physician reentry to practice; and  
19  
20 Whereas, no structured/consistent criteria or standardized processes exist across the country to  
21 facilitate reentry without subjectivity, bias or possibly arbitrariness; and  
22  
23 Whereas, there is a need for a consistent approach to reentry to practice, informed by evidence  
24 based criteria, where available; and  
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26 Whereas, the collection of relevant research and data will require multiple sources of  
27 information beyond state medical boards, including specialty societies, certification boards and  
28 post licensure training programs; and  
29  
30 Whereas, the AMA, with its broad representation within the House of Medicine has the  
31 resources to support such data collection and research; therefore be it  
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33 RESOLVED, that our American Medical Association work with the FSMB, specialty and  
34 subspecialty societies, and other relevant stakeholders to study and develop evidence-based  
35 criteria for determining a physician's readiness to reenter practice and identify resources for the  
36 evaluation and retraining of physicians seeking to reenter active practice. (Directive to Take  
37 Action)

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 4/24/2024

## REFERENCES

1. <https://www.fsmb.org/about-fsmb/>
2. <https://www.fsmb.org/siteassets/advocacy/policies/board-requirements-on-re-entry-to-practice.pdf>

## RELEVANT AMA POLICY

### Physician Reentry D-300.984

Our AMA:

1. Will continue to collaborate with other appropriate organizations on physician reentry issues including research on the need for and the effectiveness of reentry programs.
2. Will work collaboratively with the American Academy of Pediatrics and other interested groups to convene a conference on physician reentry which will bring together key stakeholders to address the development of reentry programs as well as the educational needs of physicians reentering clinical practice.
3. Will work with interested parties to establish a physician reentry program (PREP) information data base that is publicly accessible to physician applicants and which includes information pertaining to program characteristics.
4. Will support efforts to ensure the affordability and accessibility, and to address the unique liability issues related to PREPs.
5. Will make available to all interested parties the physician reentry program (PREP) system Guiding Principles for use as a basis for all reentry programs:
  - a. Accessible: The PREP system is accessible by geography, time and cost. Reentry programs are available and accessible geographically across the United States and include national and regional pools of reentry positions. Reentering physicians with families or community ties are not burdened by having to relocate to attend a program. The length of time of reentry programs is standardized and is commensurate with the assessed clinical and educational needs of reentering physicians. The cost of reentry programs is not prohibitive to the physician, health care institutions or the health care system.
  - b. Collaborative: The PREP system is designed to be collaborative to improve communication and resource sharing. Information and materials including evaluation instruments are shared across specialties, to the extent possible, to improve program and physician performance. A common nomenclature is used to maximize communication across specialties. Reentry programs share resources and create a common repository for such resources, which are easily accessible.
  - c. Comprehensive: The PREP system is comprehensive to maximize program utility. Physician reentry programs prepare physicians to return to clinical activity in the discipline in which they have been trained or certified and in the practice settings they expect to work including community-based, public health, and hospital-based or academic practice.
  - d. Ethical: The PREP system is based on accepted principles of medical ethics. Physician reentry programs will conform to physician licensure statutes. The standards of professionalism, as stated in the AMA Code of Medical Ethics, must be followed.
  - e. Flexible: The PREP system is flexible in structure in order to maximize program relevancy and usefulness. Physician reentry programs can accommodate modifications to program requirements and activities in ways that are optimal to the needs of reentering physicians.
  - f. Modular: Physician reentry programs are modularized, individualized and competency-based. They are tailored to the learning needs of reentering physicians, which prevents the need for large, expensive, and standardized programs. Physicians should only be required to take those modules that allow them to meet an identified educational need.
  - g. Innovative: Innovation is built into a PREP system allowing programs to offer state of the art learning and meet the diverse and changing needs of reentry physicians. Physician reentry programs develop and utilize learning tools including experimenting with innovative and novel curricular methodologies such as distance learning technologies and simulation.
  - h. Accountable: The PREP system has mechanisms for assessment and is open to evaluation. Physician reentry programs have an evaluation component that is comparable among all specialties. Program assessments use objective measures to evaluate physician's competence at time of entry, during the program and at time of completion. Program outcomes are measured. Reliability and validity of the measures are established. Standardization of measures exist across programs to assess whether or not national standards are being met.
  - i. Stable: A funding scheme is in place to ensure the PREP system is financially stable over the long-term. Adequate funding allows physician reentry programs to operate at sufficient and

appropriate capacity. j. Responsive: The PREP system makes refinements, updates and other changes when necessary. Physician reentry programs are equipped to address systemic changes such as changes in regulations. Additionally, the PREP system is prepared to respond efficiently to urgent health care needs within society including mobilizing clinically inactive physicians temporarily into the workforce to attend to an acute public health crisis, such as a terrorist, biological, chemical, or natural disaster.

6. Our AMA encourages each state which does not grant a full and unrestricted license to physicians undergoing reentry to develop a non-disciplinary category of licensure for physicians during their reentry process.

Citation: (CME Rep. 6, A-08; Reaffirmed: CME Rep. 11, A-12; Modified: CCB/CLRPD Rep. 2, A-14; Appended: Res. 310, A-14)

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