

Physician Reentry: Regulatory Burden or Ethical Necessity?

Physician Reentry: What You Need to Know
Educational Session, AMA Interim Meeting
November 6, 2010

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Disclosures

- Member, AMA Council on Medical Education
 - Chair, Task Force on MOC, MOL and Reentry
- Member, AAP Maintenance of Practice Workgroup
- Member, Virginia Board of Medicine
 - Chair, ad hoc Committee on Competency
- Member, FSMB Special Committee on Physician Reentry

AMA Definition of Physician Reentry

A return to clinical practice in the discipline in which one has been trained or certified following an extended period of clinical inactivity not resulting from discipline or impairment.

Distinct from remediation or retraining.

Repeat: No disciplinary or addiction related impairment issues

Why Bother?

- MOC is pushing medicine toward ongoing assessments of performance
- MOL will push all state licensing boards (SMBs) toward ongoing assessments of performance but will likely be broader than just MOC
- Hospital credentialing bodies are the leaders in requiring proof of competence
- Public demands for ongoing assessments
- Workforce needs
- Economic downturn
- New health care quality or accountability based systems ??

AMA Activities

- CME Report 6—Physician Reentry, June, 2008
- CME Report 1—Physician Reentry to Practice: Data to Guide Program Development, November, 2009
- Invitee Conference--Physician Reentry to Clinical Practice: Overcoming Regulatory Challenges, May, 2010
- Multiple conversations with multiple regulatory and certifying bodies

2008 Report

- Work with all entities interested in assessing the need for and effectiveness of reentry programs, the educational needs of reentering physicians and the cost and availability of programs
- Establish a data base of information about programs
- Developed a list of Guiding Principles for all reentry programs (see handouts!)
- Work within ITME to develop model standards for reentry programs

2009 Report

- Results of two surveys
 - State medical boards
 - 49% have a policy or regulations
 - Of the other 51%, 41% are considering developing one
 - 2.9 years is average time out before requiring a reentry program
 - 79% of boards do not have patient care requirements
 - Reentry programs—Huge variability!
 - Cost at least \$6,000 (does not include travel and housing)**
(Biggest barrier)**
 - Demographic info limited
 - 67% do a final assessment which is reported as a letter or summary
- Summary of existing issues
 - Need, Access, funding constraints
 - Lack of consistency in regulatory guidelines
 - Liability and credentialing issues
 - Lack of any form of certification after completion of programs

Reentry Conference

- Consensus on many issues
- Regulators, educators and physicians in same room
- Need for specialty involvement
- Need for research on time frame
- Need to minimize barriers
- Need for model program guidelines
- Priorities set for procedural vs. cognitive

But...To be Honest...

- No evidence on length of time out
- No idea how big the pool is
- No agreed upon criteria on how to define or assess competence
- No standardization of programs
- No clear final certification
- No specialty licensure in any state
- No cheap, regional, accredited programs
- No clear educational guidelines

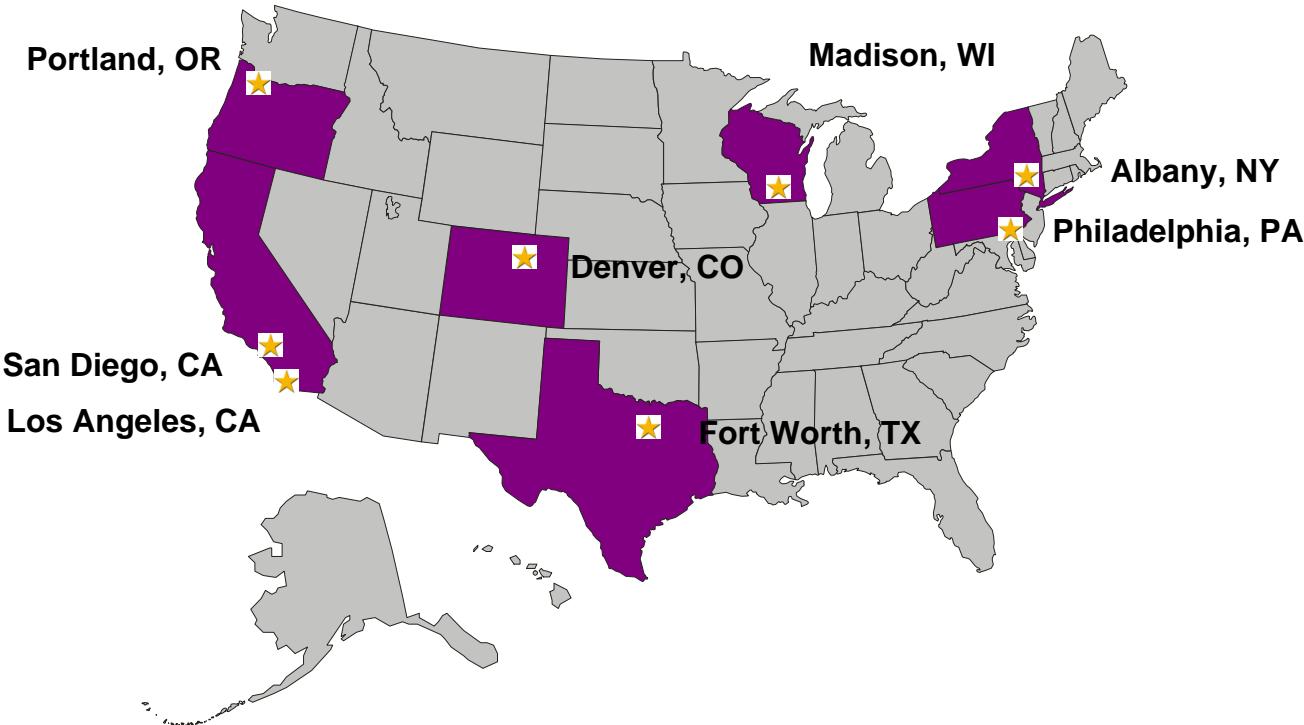
Time and Talent

- SMBs have times from 1 years to 10—average is 2.9 years
- Some evidence that age is factor in competence
- More men than women
- Multitude of reasons to leave and come back
- Most states have not tracked. Estimates from 10-18% could potentially reenter.
 - Arizona survey says 1.5% a year or 10,000 per year nationwide
- MOC and MOL may uncover more
- Workforce, geographic and economic implications

The Reentry Programs

- Existing programs listed on handout
 - NC not on list
 - Limited geographically, expensive
 - All different but many are AMC based
 - Majority were originally remediation driven
 - SMBs trust them
- Debate about how to individualize reentry
 - Procedural different from cognitive
 - Mentors—liability/training/quality
 - Follow-up—who responsible/how long/limits on practice
- Role of AMCs and hospitals
- Funding
- Final certification—what does a SMB need?
 - Ties to MOL and MOC?

Location of Physician Reentry Programs in the US



Maintenance of Certification

- MOC is best tool for “competency” assessment that we currently have but it is not geared for reentry
 - Cannot do PI and practice self assessment when not practicing
 - Must have current, active license
 - Procedural skills not adequately assessed
 - Grandfathered/non-boarded/administrative cohorts
- MOC generalized within specialty while reentry may need to be very specific for each physician
- Need “Boots on the Ground” type of assessments of “performance in practice”
 - Mini-residency
 - Simulations
 - Mentoring/proctoring

Maintenance of Licensure

- FSMB has passed MOL guidelines—now developing implementation guidelines
 - MOC is only one of many modalities a licensing board can adopt to meet MOL requirements
 - MOL will be expensive and high maintenance
- Both MOC and MOL are likely to push licensing boards towards a much higher standard for re-licensure than paying fee and attesting to CME hours.
- Licensure now is for General Undifferentiated Medical Practice (GUMP). Is specialty licensure the next step?
- MOL will have financial and personnel implications for SMBs.
- Remember that self-regulation is at stake...

Liability Insurance

- The door swings both ways
 - Programs and mentors/proctors want to be indemnified against learner's mistakes
 - Learner does not want to go bare either
- Might be expensive
 - Do you have ongoing insurance? Do you have a “tail”?
 - Do you need full insurance or just “some”?
- What are the insurers insuring?
 - They insure patient care—if none, they are flummoxed
 - They are risk averse and do not quite understand this issue—so not anxious to insure either the programs or the learner

The moral of the story...

- For all of us, ongoing assessment of our abilities as physicians is both an ethical and legal responsibility
- Protection of our right to self-regulation means taking responsibility for valid proofs of competency
- Flying under the radar by keeping your GUMP license will not protect the patients or you
- The topic of reentry is a moving target
 - Linked to MOL
- AMCs, specialty societies and boards need to help—where is our “educational home”?

So, now what?

- Go to the AAP website for prevention and planning strategies
- Urge your medical schools, residency sites, specialty societies and boards to research the needs, set guidelines for special knowledge or procedure testing and support some form of uniform requirements
 - Training, selection and approval of mentors and proctors
 - Feedback and input into current programs
- Do the necessary research
- Resist any federal legislation that will open the door to either specialty licensure or federal licensure
- Speak up to the AMA about your concerns and good ideas.

Thanks!

- THE WPC and its leadership
- Saralyn Mark for carrying the torch
- The AAP—Holly Mulvey and Kelly Towey
- The AMA—Carl Sirio, the Council on Med Ed, Susan Skochelak, Barbara Barzansky, Gretchen Kenagy and all the staff
- The FSMB—Barbara Schneidman, Hank Chaudhry, Freda Bush, Marty Crane and Frances Cain
- The leadership of all the programs and the CPE that is doing the educational research
- All of the “Reenterers” who have shared their stories and their insights

*Questions? Comments?
Stories?*

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