

Report of the Special Committee on Reentry for the Ill Physician
Adopted as policy by the House of Delegates of the Federation of State Medical Boards
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REPORT OF THE SPECIAL COMMITTEE ON REENTRY FOR THE ILL PHYSICIAN

EXECUTIVE SUMMARY

The Special Committee on Reentry for the Ill Physician was convened in 2012 by Federation of State Medical Boards (FSMB) Chair Lance Talmage, MD, to address the return to practice for physicians who have a licensure restriction due to physical or psychiatric illness, including addictive disease.

Reentry to clinical practice for ill physicians is a complex, multi-faceted issue. In addressing this issue, two key distinctions should be kept in mind:

1. a license restriction due to medical fitness to practice concerns is importantly different from a license restriction containing a restricted practice clause and does not necessarily imply a lack of professionalism on the part of the physician, nor that he or she is unable to practice safely, and
2. the terms “illness” and “impairment” are not synonymous. Illness is the term used to describe the existence of a disease state. It can be physical or psychiatric and can include addictive disease, injury and cognitive change. Impairment, however, is a functional classification that implies the inability of the person affected by a disease to perform activities specific to practice.¹

Further, physicians who have made successful efforts to address their illness and are able to demonstrate the ability to practice safely should not feel further encumbered or penalized as a result of license restrictions that are interpreted negatively. It is also important that such restrictions not impact physicians’ ability to obtain or maintain specialty board certification, malpractice insurance, medical insurance provider panel membership, hospital privileges or employment.

The Special Committee’s primary goal is to ensure the capability of formerly ill physicians to provide safe, effective patient care. The recommendations in this report are presented to state medical boards, American Board of Medical Specialties (ABMS) and American Osteopathic Association Bureau of Osteopathic Specialists (AOA BOS)-approved specialty boards, health insurers, physician health programs, health care organizations and state government agencies to assist them in ensuring that physicians who have been ill are capable of practicing safely and may reenter the workforce, under adequate supervision and continued treatment, if necessary for their recovery. The recommendations encourage common standards and terminology around license restrictions and encourage these stakeholders to better understand state boards’ positions on restricted licensure status as it relates to medical fitness to practice.

Specific recommendations include the following:

- Physicians seeking to return to clinical work following an illness should have their ability to practice considered on a case-by-case basis.

¹ FSPHP Public Policy Statement: Physician Illness vs. Impairment, 2008.

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- A physician who has been out of practice for an extended period of time should be required to participate in a reentry plan as outlined in the 2012 report of the FSMB's Special Committee on Reentry to Practice.
- State boards should become familiar with the FSMB's Policy on Physician Impairment and consult state physician health programs for assessment and monitoring services in cases where further evaluation or assessment of an ill physician is required.
- Decisions about a physician's specialty board certification status, malpractice insurance, medical insurance provider panel membership, hospital privileges and/or employment should be based on a thorough review and consideration of all available information about the physician's illness and any relevant actions taken by state boards.
- Clear, common nomenclature is critical to ensuring that ill physicians are able to successfully return to clinical practice. The FSMB and state boards should look for opportunities to clarify and to standardize, to the extent possible, the language and information used as part of state boards' licensing and disciplinary processes.
- State boards may wish to consider the terminology used in board actions to determine whether the nature of the action is appropriately conveyed and is not open to misinterpretation by other entities.

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I. BACKGROUND

The safe and effective practice of medicine requires physicians to be physically and mentally fit for the work they do. The impact of a physician's illness on medical practice is a complex, multi-faceted subject. In evaluating this issue, the Federation of State Medical Boards' (FSMB) Special Committee on Reentry for the Ill Physician recognizes the generally unique stressors faced by physicians in practice and also the impact that illness can have on a physician and his/her practice, patients, career, peers, and family. Factors such as burnout, depression, and suicide have been specifically identified as particular challenges within the physician community. Organizations such as the American Medical Association (AMA), Federation of State Physician Health Programs (FSPHP) and others have developed policy documents, recommendations and guidelines to assist physicians with addressing these challenges and to explore and clarify the issues surrounding physician illness and its impact (see [Appendix A](#) for a list of resources). Medical regulatory concepts of illness, however, have historically focused on addiction and depression. In addition, important distinctions between illness and impairment have not been emphasized.

In 1993, the FSMB convened an Ad Hoc Committee on Physician Impairment to evaluate current concepts regarding physician impairment and to develop strategies for the regulation and management of such physicians. Subsequently, in 1995, the FSMB House of Delegates (HOD) adopted as policy the Report of the Ad Hoc Committee on Physician Impairment², which identified elements of a model impaired physicians program for recommendation to state boards along with guidelines to promote uniformity in rules and regulations regarding impaired physicians. An updated Policy on Physician Impairment was adopted in 2011 following review and revision of the Report of the Ad Hoc Committee on Physician Impairment.³ The revised policy document represents a vision for state boards and physician health programs based on current best practices to effectively assist ill physicians who are impaired or at risk for impairment.

The FSMB has also recently addressed the issue of reentry to practice for physicians who were neither ill nor have a license restriction, through the adoption in April 2012 of its Report of the Special Committee on Reentry to Practice.⁴ This Report provides state boards with a framework of common standards and conceptual processes for physician reentry to the clinical practice of medicine.

Physicians whose illness has resulted in state board action often face unique challenges to reentry to practice, particularly in terms of the ability to obtain and/or retain specialty board certification, malpractice insurance and employment. Recognizing this fact, in summer 2012, FSMB Chair Lance Talmage, MD, convened a Special Committee on Reentry for the Ill Physician to address these issues and to provide recommendations to state boards for their consideration and adoption.

II. CHARGE TO THE SPECIAL COMMITTEE ON REENTRY FOR THE ILL PHYSICIAN

The Special Committee on Reentry for the Ill Physician was charged to address the return to practice for physicians who have a licensure restriction due to physical or psychiatric illness, including addictive disease.

² Federation of State Medical Boards. Report of the Ad Hoc Committee on Physician Impairment, April 1995. Available at: http://www.fsmb.org/pdf/1995_grpol_Physician_Impairment.pdf

³ Federation of State Medical Boards. Policy on Physician Impairment, April 2011. Available at: http://www.fsmb.org/pdf/grpol_policy-on-physician-impairment.pdf

⁴ Federation of State Medical Boards. Report of the Special Committee on Reentry to Practice, April 2012. Available at: <http://www.fsmb.org/pdf/pub-sp-cmt-reentry.pdf>

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III. PREAMBLE / KEY ISSUES

In considering reentry to practice for the ill physician, the Special Committee noted the need for clarification of the distinction between illness and impairment. For example, many, if not most, physicians who go through Physician Health Programs (PHPs) are ill but not impaired; that is, the impairment involved is merely potential, rather than active. Illness is the term used to describe the existence of a disease state. It can be physical or psychiatric and can include addictive disease, injury and cognitive change. In contrast, impairment is a functional classification that implies the inability of the person affected by a disease to perform activities specific to practice.⁵

It is worthy to note that not all physicians who are ill will, or need to, come to the attention of a state board. In some instances, the physician is able to appropriately limit his or her practice and/or to obtain appropriate and successful treatment and remediation before the illness impacts the physician's ability to provide safe, effective patient care. In order to avoid treating all ill physicians as if they were impaired, and to avoid undue burdens on such physicians at the point of reentry to clinical practice, it is critical that the terms "illness" and "impairment" not be construed as interchangeable as part of regulatory processes.

Physicians who choose – or due to the severity of their illness are forced – to take time out of their medical practice to address their own health care needs often face significant challenges at the point of reentry to clinical practice. Some physicians, particularly those whose illness was significant enough to warrant attention by a state board, may find particular challenges to obtaining or retaining specialty board certification, malpractice insurance, employment, membership in medical insurance provider panels, or hospital privileges due to restrictions placed on their licenses as part of a board action and the reentry process. Such restrictions are primarily utilized by state boards to ensure public protection against unsafe practitioners. However, license restrictions may or may not include a condition of *restricted practice*. In this context, there is often significant confusion and lack of understanding regarding the word "restriction" and how it affects an ill physician's ability to practice, a fact that sometimes is a detriment to physicians who are ill.

A license restriction due to medical fitness to practice concerns (e.g., practice monitoring, treatment monitoring by a PHP or other designated entity, including periodic drug screening) is importantly different from a license restriction containing a restricted practice clause (e.g. work hour limitation, loss of prescribing privileges, mandatory presence of a chaperone) and does not necessarily imply a lack of professionalism on the part of the physician, nor that he or she is unable to practice safely. In fact, such a restriction is different from a restricted practice clause in that it is meant to assure the public of the physician's medical fitness to practice within the Board's defined parameters. Further, engagement with a PHP may assist a physician in achieving and maintaining a safer practice than would be possible otherwise. Even in cases in which a physician's scope of practice is limited due to illness, this does not imply that he or she is incompetent or unsafe within the *restricted* scope of practice. For example, a surgeon who is restricted from providing procedural care due to a personal hand injury that impacts his or her ability to perform surgical procedures may limit his or her practice for a period of time to patient consultations. Similarly, an anesthesiologist who is undergoing treatment for a drug addiction and submits to periodic drug testing could be allowed to retrain in another field where drug exposure is not an issue. These restrictions are based on considerations of medical fitness to practice and are different from restrictions due to concerns about a physician's professionalism or competence.

⁵ FSPHP Public Policy Statement: Physician Illness vs. Impairment, 2008.

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In regard to the relationship between specialty board certification and licensure status, the 24 member boards of the American Board of Medical Specialties (ABMS) commonly use licensure status as one measure of professionalism. Specifically, Part I of the ABMS' Maintenance of Certification (MOC) program requires physicians to hold a valid, unrestricted medical license. However, there is variation in how the ABMS member boards address the issue of physicians with a restricted license status. Some boards revoke a physician's specialty board certification or do not allow the physician to participate in MOC, while others will allow the physician to maintain his or her specialty certification and to continue to participate in MOC. The decision as to whether the licensure restriction will impact the physician's specialty board certification status is based on a review of the nature of the restriction, as well as the reasons and their relevance to the physician's scope of practice. Revocation of a physician's specialty board certification can have further implications for the physician's license, ability to obtain employment, or ability to obtain or maintain hospital staff privileges, an issue of discussion among the ABMS, FSMB and state boards.

Similarly, the American Osteopathic Association Bureau of Osteopathic Specialists (AOA BOS) also requires an unrestricted medical license for initial specialty board certification, recertification and participation in Osteopathic Continuous Certification (OCC). Physicians with a restricted license are usually able to petition their specialty board to enter the certification or recertification process, however, based on a review of the reason for the restriction.

The Special Committee recognizes the value of physicians as a community and public resource, especially in underserved areas and in light of current concerns about physician shortages. As such, while the committee's primary goal is to ensure the capability of formerly ill physicians to provide safe, effective patient care, the committee also acknowledges the need to enable physicians who are capable of practicing safely to reenter the workforce, under adequate supervision and continued treatment, if necessary for their recovery.

IV. RECOMMENDATIONS

The following recommendations are intended to provide state boards, ABMS and AOA-approved specialty boards, health insurers, physician health programs, health care organizations and state government agencies with a framework for developing common standards and terminology around license restrictions. They also encourage these stakeholders to better understand state boards' positions on restricted licensure status as it relates to medical fitness to practice.

To the extent possible, the recommendations are intended to align with the recommendations set forth in the FSMB's Report of the Special Committee on Reentry to Practice, which was adopted as FSMB policy in April 2012. Readers are encouraged to read that report for detailed reentry recommendations for physicians without illness, impairment or disciplinary issues.

DETERMINING MEDICAL FITNESS TO REENTER PRACTICE

Recommendation 1: Review on a Case-by-case Basis

Physicians seeking to return to clinical work following an illness that resulted in board action should have their ability to practice considered on a case-by-case basis. Decisions about whether the physician should demonstrate readiness to reenter practice should be based on a global review of the physician's situation, including nature of the illness, treatment and remediation received for the illness or impairment, processes in place for continued or follow up treatment or monitoring, length of time out of practice, prior and current (or

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intended area) of specialization, disciplinary history and hospital privileges. Physicians, like non-physicians, demonstrate varying levels of resiliency in terms of being able to successfully cope with a range of illnesses, even those that do not compromise a physician's ability to practice safe, effective patient care. Therefore, state boards should adopt a holistic approach when evaluating a physician's ability to reenter practice and take into account factors such as the personal and professional support system available to the physician.

Recommendation 2: Familiarity with Relevant FSMB Policies and Other Resources

State boards should become familiar with the FSMB's *Policy on Physician Impairment* and consult state physician health programs for assessment and monitoring services in cases where the board determines the need for further evaluation or assessment of an ill physician. The list of resources provided in [Appendix A](#) may also be useful to the board and the individual physician.

Recommendation 3: Reentry Plan after Extended Time out of Practice

Exclusive of issues and challenges specific to the physician's illness, a physician who has been out of practice for an extended period of time should be required to participate in a reentry plan as outlined in the 2012 report of the FSMB's Special Committee on Reentry to Practice.⁶

COMMON TERMINOLOGY AND REVIEW OF RELEVANT INFORMATION

Recommendation 4: Common Terminology

Use of clear, common nomenclature among state boards is critical to ensuring that ill, or formerly ill, physicians are able to successfully return to clinical practice. Currently, use of language such as "license restriction" by a state board is often interpreted by other stakeholders (e.g., ABMS and AOA-approved specialty boards, insurers, physician health programs, health care organizations and government agencies) to mean that the action taken is disciplinary in nature or that the physician is incompetent, when it ought, in fact, to be an assurance that the physician is capable of practicing medicine safely.

In order to promote a clearer understanding of license restrictions and their implications, the FSMB should facilitate a dialogue among and with its member boards and other stakeholders about the terminology used as part of licensing and disciplinary processes. Central to this outreach should be the education of stakeholders about how restrictions on a physician's license do not necessarily imply the physician is unable to practice medicine safely, that he or she has displayed a lack of professionalism or that his or her scope of practice has been restricted in any way.

In addition, state boards may wish to consider using the term "license limitation" or some other standardized term which indicates a safe practitioner with some form of supervision or partial limitation, rather than "license restriction", and use terminology such as "letters of agreement", "consent agreement" or "agreement for corrective action" to better convey the nature of the action and in order to lessen misinterpretation of the action by other entities. The FSMB and its member boards should also look for opportunities to clarify and to standardize, to the extent possible, the language and information used as part of the state boards' licensing and disciplinary processes. As part of this effort, the FSMB may want to consider providing recommendations

⁶ Federation of State Medical Boards. Report of the Special Committee on Reentry to Practice, April 2012. Available at: <http://www.fsmb.org/pdf/pub-sp-cmt-reentry.pdf>.

Note: More than two years away from practice is commonly accepted as the timeframe for when physicians should go through a reentry process, although some state medical board requirements range from one to five years.

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for clarifying language as part of future revisions of its *Essentials of a State Medical and Osteopathic Practice Act* document.⁷

Recommendation 5: Sharing and Review of State Medical Board Orders

Given the potential for confusion and misinterpretation of language used as part of the medical licensing and disciplinary process, decisions by various stakeholders about a physician's specialty board certification status, malpractice insurance and/or employment should be based on a thorough review and consideration of all available information about the physician's illness and any relevant actions taken by state boards. The FSMB, via its board action reports and Disciplinary Alert Service, provides to the public, hospitals, ABMS and AOA-approved specialty boards, and other relevant stakeholders, information regarding public board actions taken by all state boards. Information regarding the general nature of the disciplinary action taken by the state board (e.g., revocation of medical license, license restored/reinstated with restrictions/limitations), as well as the basis for the action (e.g., impairment, sexual boundary violation), are included as part of the report. Upon receiving such a report from the FSMB, it is incumbent upon ABMS and AOA-approved specialty boards, insurers and employers to carefully review and consider the information before coming to a decision about a physician's ability to obtain or maintain specialty board certification, or obtain malpractice insurance or employment. Those reviewing these documents should determine whether or not the board action relates to medical fitness as opposed to professionalism or competence.

Currently, the board action reports and Disciplinary Alert Service notifications provided by the FSMB do not include the full details of the board's action, or findings of fact associated with the reported disciplinary action(s). In addition, the language and terminology used in board actions is not standardized across jurisdictions, or may be antiquated, resulting in confusion for external entities that receive and attempt to interpret board action reports. As such, and as noted above, consideration should be given to changing the nomenclature used as part of the medical licensing and disciplinary process to avoid confusion regarding illness, impairment and other reentry to practice issues. The FSMB and its member boards should also consider whether full board actions (sometimes also known as orders) and/or findings of fact should be included as part of the standard board action report and Disciplinary Alert Service notification. Such information might provide details useful in determining whether to allow a physician to obtain or maintain specialty board certification, malpractice insurance or employment. In the absence of such information, external stakeholders should consider requesting further clarification or explanation from the state board and/or physician in order to assist them in their informed decision-making process. Most state boards include full board orders as part of the disciplinary history information included as a component of the practice profile publically available on their state-based websites.

V. IMPLICATIONS FOR STATE MEDICAL BOARDS AND THE ROLE OF THE FSMB

The FSMB should engage in further education and communication outreach with external stakeholders, including ABMS and AOA-approved specialty boards, insurance companies, residency programs, hospitals and other employers, professional associations and the public, to ensure the value of the recommendations in this report. Such efforts can take place through multiple educational opportunities, including formal presentations, one-on-one conversations, communication toolkits (e.g., FAQs), and articles / editorials (in medical journals and other relevant publications such as insurance journals).

⁷ Federation of State Medical Boards. *Essentials of a State Medical and Osteopathic Practice Act*, April 2012. Available at: http://www.fsmb.org/pdf/GRPOL_essentials.pdf

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The FSMB should also continue its dialogue and education efforts with the ABMS, the AOA BOS and individual ABMS and AOA-approved specialty boards about the relationship between specialty board certification and licensure and the intended and unintended impact of loss or restriction of one on the other.

VI. CONCLUSION

Reentry to clinical practice for ill physicians is a complex, multi-faceted issue. All physicians provide valuable resources to their communities and should not be routinely penalized as a result of past or current illness that does not currently impact their ability to practice safely. Physicians who have made successful efforts to address their illness and are able to demonstrate the ability to practice safely should not feel further encumbered or penalized as a result of license restrictions that are interpreted negatively and that impact their ability to obtain or maintain specialty board certification, malpractice insurance, medical insurance provider panel membership, hospital privileges or employment.

As the healthcare community continues to address the issue of the ill physician and his or her continuance of or return to practice, two key distinctions should be kept in mind: 1) the term restriction, when applied to a physician's license, does not necessarily imply that his or her scope of practice has been limited in any way, that he or she has displayed a lack of professionalism, or that he or she is unsafe when practicing within that scope, and 2) the terms "illness" and "impairment" are not synonymous. A physician who is or has been ill is not necessarily impaired and may be able to function effectively and practice safely, especially with participation in relevant treatment programs and ongoing monitoring, where appropriate. Engagement with a physician health program may even assist a physician in achieving and maintaining a safer practice than before.

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APPENDIX A

Resources related to Physician Health, Illness and Impairment and Physician Reentry to Practice

American Medical Association. *AMA Healthier Life Steps: A Physician's Guide to Personal Health, Practical Steps to Resilience*, 2011, available at: <http://www.ama-assn.org/resources/doc/public-health/steps-for-resilience.pdf>

American Medical Association. Compendium of Policies on Physician Health, available at: <http://www.ama-assn.org/resources/doc/physician-health/policies-physicain-health.pdf>

American Medical Association, Council on Ethical and Judicial Affairs. *Physician Health and Wellness*, CEJA Report 5-I-03, available at: www.ama-assn.org/resources/doc/code-medical-ethics/9031b.pdf

American Medical Association, Council on Science and Public Health. *Physician Health Programs*, CSPH Report 2 (A-11), available at: <http://www.ama-assn.org/resources/doc/csaph/a11csaph2.pdf>

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Federation of State Physician Health Programs. FSPHP Public Policy Statement: Physician Illness vs. Impairment, 2008. Available at: http://www.fsphp.org/Illness_vs_Impairment.pdf

Federation of State Physician Health Programs. *Physician Health Program Guidelines*, December 2005 Edition, available at: http://www.fsphp.org/2005FSPHP_Guidelines.pdf

Health Law Institute, Faculty of Law, University of Alberta. Physicians with Health Conditions: Law and Policy Reform to Protect the Public and Physician-Patients, available at: www.hli.ualberta.ca/ResearchandResearchPublications/-/media/hli/Physicians_with_Health_Conditions_Complete.pdf

The Physician Reentry into the Workforce Project: <http://physician-reentry.org/>

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