

Center for Transforming Medical Education

Physician re-entry to the workforce: Recommendations for a coordinated approach



The American Medical Association defines **physician re-entry** 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.

There are many reasons why a physician might take a voluntary leave of absence from clinical practice, including family leave (maternity and paternity leave, child rearing), other caretaking and relationship issues, personal health reasons, career dissatisfaction and alternate careers such as administration, military service and humanitarian leave.

Physicians wishing to return to clinical practice after a period of clinical inactivity may experience difficulties due to the lack of a comprehensive re-entry system in the United States. This can result in barriers at a number of levels:

The individual physician

- Lack of information on the re-entry process and the requirements for re-entry
- High monetary and opportunity costs of participating in re-entry programs
- Lack of geographical access to the limited number of re-entry programs currently available

The re-entry program

- Lack of information on the number of physicians needing a re-entry program
- Lack of ability to certify competence after program completion
- Lack of an assessment process, including appropriate assessment tools, for participants and programs
- Difficulty balancing comparability across programs with the need for individualized education and training for program participants

The regulatory process

- Lack of consistency in state medical licensing laws and regulations
- Lack of a database on reentering physicians and physicians needing a re-entry process
- Constraints related to credentialing and medical liability coverage for reentering physicians
- Issues related to maintenance of certification for inactive physicians

In addition to these concerns, physician re-entry has significant implications for the overall health care workforce. Demographic changes in the population (and in medicine itself), as well as the passage of health system reform, have led to increased awareness of the need for more physicians in certain disciplines and regions. Easing the re-entry process can help address this concern.

The American Medical Association (AMA) worked with a wide range of stakeholders—including leaders in licensure, board certification and medical education, as well as directors of re-entry programs—to develop the following recommendations on physician re-entry . During the consensus process to develop these recommendations, it became clear that to coordinate regulatory and programmatic aspects of physician re-entry effectively a comprehensive evidenced-based approach was needed.

The following recommendations, which are meant to ease a range of barriers to physician re-entry , should be considered in their entirety. Taken together these measures outline a coordinated approach to physician re-entry .

Recommendations

Regulatory policies

Principle: Ensure that there is a comprehensive, transparent and feasible regulatory process for physicians to return to clinical practice.

1. Develop an understanding of the expectations and needs that relevant stakeholder groups—physicians, patients, regulators and the public—have for a physician re-entry system.
2. Develop physician re-entry 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 re-entry process
 - The definition of how much involvement in clinical care constitutes active clinical practice and the clinical practice requirements for maintaining licensure
 - 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 re-entry 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 that allow re-entry program participants to work under supervision
 - State medical licensing boards that establish a non-disciplinary licensure status option for reentering physicians during their re-entry education and training

- Development and validation of a process for previously board certified physicians not eligible for maintenance of certification to participate in re-entry training necessary to return to their field and original scope of clinical practice

4. Work with state medical licensing boards and medical societies to develop a certificate of program completion that meets the need to document physician readiness for clinical practice.

Physician re-entry program policies

Principle: Develop policies that assure the quality of re-entry programs and the readiness to resume practice of their graduates.

5. Increase consistency among re-entry programs by establishing a mechanism by which programs can assess and demonstrate graduates' comparable preparation and readiness for independent practice within the physician's intended scope of practice.
6. Encourage the development of modular programs to meet the specific learning needs of individual reentering physicians.
7. Consider a physician re-entry program accreditation process that includes a review of program outcomes.

Research and evaluation

Principle: Create an evidence base that can be used to inform policymakers, reentering physicians and re-entry program development.

8. Study the feasibility of introducing alternate licensure tracks for reentering physicians that allow a limited scope of practice.

- 9.** Study the relationship between time away from practice and maintenance of clinical knowledge, skills and behaviors.
- 10.** Study new models of organizing physician re-entry programs to include the feasibility of providing physicians with an educational “home” base.
- 11.** Continue to develop valid and reliable assessment tools for physician knowledge and skills. Assessment of reentering physicians should occur at three points: (1) entry to a physician re-entry program, (2) completion of a physician re-entry program, and (3) a standard time after which a physician has returned to active clinical practice.
- 12.** Establish a national physician re-entry database to:
 - Provide programmatic information to reentering physicians
 - Track trends in re-entry such as number of reentering physicians, program costs and outcomes
- 13.** Study the workforce implications of a system that supports physician re-entry .

Program funding

Principle: Develop means to ensure that a physician re-entry system is financially feasible.

- 14.** Pursue multiple funding streams to support the development, implementation and evaluation of a national physician re-entry system.

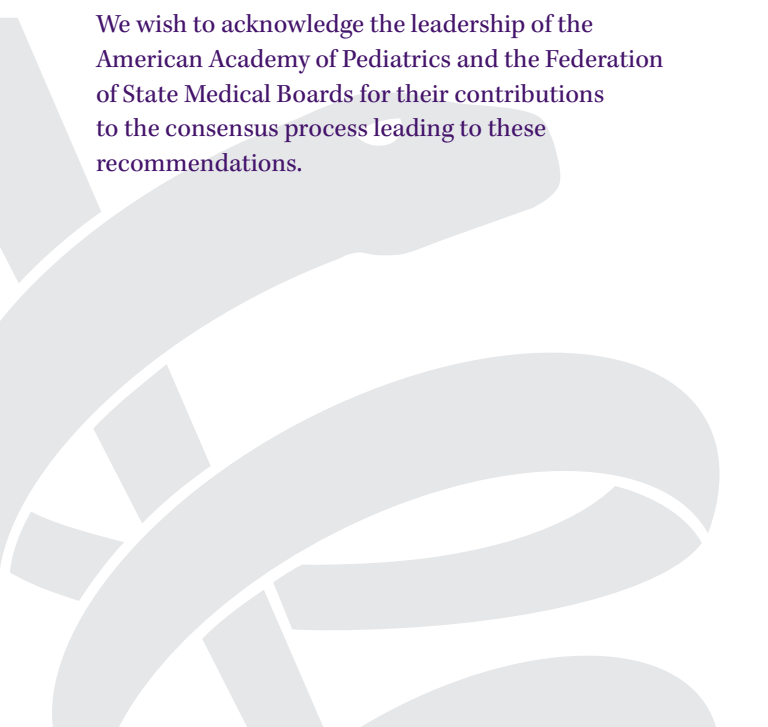
Collaboration and communication among stakeholders

Principle: Ensure that all stakeholders participate in planning for a physician re-entry system.

- 15.** Establish process for ongoing communication between medical regulatory bodies, physician re-entry programs, medical associations and societies, and other key stakeholders to further the development of a national re-entry system.
 - Mitigating the cost of physician re-entry programs for physicians and regulatory bodies
 - Supporting the development and maintenance of physician re-entry programs
 - Creating mechanisms for the assessment and evaluation of physician re-entry programs

- 16.** Continue to educate medical students, residents and practicing physicians on career-planning strategies and resources should they need to take a hiatus from clinical practice.

We wish to acknowledge the leadership of the American Academy of Pediatrics and the Federation of State Medical Boards for their contributions to the consensus process leading to these recommendations.



Visit the following web sites for more information:

www.ama-assn.org/go/reentry

www.physicianreentry.org

