

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 1-I-09

Subject: Physician Reentry to Practice: Data to Guide Program Development

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1 INTRODUCTION

2
3 Recommendation 6 of Council on Medical Education (CME) Report 6 (A-08), on physician reentry
4 states: “That our AMA, as part of its Initiative to Transform Medical Education (ITME) strategic
5 focus and in support of its members and Federation partners, develop model program standards
6 utilizing physician reentry program system Guiding Principles with a report back at the 2009
7 Interim Meeting.”

8
9 Ten recommendations for change in the system of medical education have been identified as part of
10 the ITME. One recommendation aims to make physician career paths more flexible.

11
12 “Consider creating alternatives to the current sequence of medical education continuum,
13 including introducing options so that physicians can re-enter or modify their practice.”¹

14
15 The CME has been working for the past several years to develop policies and strategies in support
16 of this recommendation. A CME Task Group on Career Paths has been addressing the overlapping
17 issues of physician reentry and retraining. (The issue of physician remediation, also addressed by
18 the Task Group is the topic of CME Report 3 (A-09.) The Task Group has created the following
19 definitions to facilitate discussion and action on these areas:

- 20
21 • Physician reentry: A return to clinical practice in the discipline in which one has been trained
22 or certified following an extended period of clinical inactivity not resulting from discipline or
23 impairment.
24 • Physician retraining: The process of updating one’s skills or learning the necessary skills to
25 move into a new clinical area (CME Report 6 (A-08).)

26
27 This informational report presents findings from two surveys on physician reentry. Information
28 from these surveys is being used to guide planning for model programs, as requested in CME
29 Report 6 (A-08.)

30 31 THE EVOLUTION OF THE CONCEPT OF “REENTRY”

32
33 Historically, the term “retraining” was used in reference to preparing physicians to reenter practice
34 after an absence (CME Report 5, I-94.) For example, in 1966, a pilot project was undertaken by
35 the Pacific Medical Center in San Francisco to “retrain” inactive physicians. The project,
36 supported by a contract with the Public Health Service, retrained nineteen physicians during a two-
37 year time period. Interest in retraining prompted the AMA to survey 1,874 inactive physicians
38 under 55 to explore interest in retraining among the participants and potentially, identify a need for

1 future programs. Fifty-seven percent (n=1,075) of respondents “indicated an interest in
2 retraining.”²

3
4 Between 1982 and 1992, 234 physicians enrolled in a Medical College of Pennsylvania (MCP)
5 retraining program to prepare clinically inactive physicians to return to practice. Although the
6 original stated purpose of the program was to help physicians reenter practice, a large percentage of
7 participants used it as an aid to change specialties.

8
9 More recently, a study of physicians in Arizona found that among 604 physicians who reported
10 returning to clinical practice between 2003-2006, about 45 (7%) returned to a specialty different
11 from the one they left.³ Many of the programs related to specialty change were either discontinued
12 or never came to fruition due in part to lack of funding and disinterest in retraining among
13 physicians.⁴

14
15 In order to enhance clarity of purpose, the term reentry came to be used specifically for physicians
16 desiring to resume practice after an interval, while retraining came to be applied to physicians
17 wishing to learn the skills necessary to move into another area of practice (CME Report 6, A-08.)

18 19 SUMMARY OF FINDINGS FROM TWO SURVEYS ON PHYSICIAN REENTRY

20
21 Two surveys inform this report: 1) 2010 Physician Licensure Survey – Questions on Physician
22 Reentry to Practice and 2) the Physician Reentry Program Questionnaire. The first was prompted
23 by inquiries from state medical boards seeking direction from the AMA on developing physician
24 reentry policy. The second was developed to address Recommendation 6 of CME Report 6 (A-08)
25 and to gain a better understanding of physician reentry from the perspective of reentry programs.
26 Questions for both surveys evolved from many physician reentry-related activities: The AMA-
27 AAP Physician Reentry into the Workforce conference, the Coalition for Physician Enhancement
28 Conference on reentry, discussions with stakeholders in medical education, discussions with
29 physician reentry program directors, and literature review.

30 31 *Survey 1: 2010 Physician Licensure Survey – Questions On Physician Reentry Into Practice*

32
33 The AMA annually publishes the *State Medical Licensure Requirements and Statistics*. The
34 process of compiling information for this annual publication includes sending a questionnaire
35 (*Physician Licensure Survey*) to state medical boards. In 2009, two questions on physician reentry
36 were added to the survey: 1) Does your board have a policy on physician reentry for physicians
37 who have left the active practice of medicine and want to reenter practice? and 2) What is the
38 length of time away from practice after which a reentry program is required? In an effort to further
39 explore the issue of physician reentry among state medical boards, additional questions on reentry
40 were added to the 2010 edition. The questions on physician reentry were sent, along with the 2010
41 *Physician Licensure Survey*, to 68 Boards of Medicine. Fifty-three boards responded (78% of the
42 total). A summary of the aggregate findings is presented here. The findings represent a “snapshot”
43 of specific physician reentry-related regulations and procedures among state medical boards.

44 45 Physician Reentry Policy, Length of Time Out of Practice, and Reentry Program Referral

46
47 Respondents were asked if the board has a policy on physician reentry (as defined by the AMA) for
48 physicians who have left the active practice of medicine and want to reenter practice. Just under
49 half (49%) of medical boards responded that they have a policy on physician reentry while 51%
50 have no formal policy. Among the medical boards without a physician reentry policy, about two-
51 fifths (41%) are either currently developing or planning to develop a reentry policy.

1 Among medical boards with a physician reentry policy, the average length of time out of practice
2 after which they require reentering physicians to complete a reentry program is 3.2 years and
3 ranges from 1 to 5 years. Almost two-thirds (64%) of these medical boards recommend specific
4 physician reentry programs to the reentering physicians.

5 6 Patient Care Requirements for Relicensure

7
8 The majority of medical boards (79%) do not require a physician to engage in a certain amount of
9 patient care for relicensure.

10 11 *Survey 2: Physician Reentry Program Questionnaire*

12
13 The survey was sent to physician reentry program directors as well as to directors of programs that
14 provide physician reentry services, but are not strictly as reentry programs. The survey includes
15 questions on demographics, program processes, and program outcomes. The survey also included
16 a section that asked program directors to rank the importance of the AMA's 10 guiding principles
17 for a physician reentry program system. The survey was sent to the directors of 10 programs and 6
18 program directors responded. (Program directors were promised confidentiality, therefore, names
19 of the programs are not listed in this report.) Findings are presented in aggregate.

20 21 Program Demographics

22
23 All of the programs started between 1996 and 2007. The length of time it takes physicians to
24 complete a reentry program varies, but generally takes between 6 weeks and 12 months. The cost
25 to attend a program, not including living or travel expenses, depends on the type and duration of
26 the program; however, all programs cost at least \$6,000.

27
28 In general, programs do not serve a large number of physicians. For the four programs that had
29 these data available, the average number of reentering physicians since the programs' inception
30 was 24. The average number of physicians who made inquiries to these same four programs in
31 2008 was 51; on average 13 physicians entered one of the programs during that year.

32 33 Program Participants

34
35 The average age of program participants is approximately 51 years. The majority of programs
36 indicated that they served a higher percentage of male (than female) physicians. The percentage of
37 program participants who lived locally ranged from 0 to 70. The majority of program participants
38 had an active medical license. Between 54 and 100 percent of the reentering physicians
39 successfully completed their programs.

40 41 Finding Programs and Referrals

42
43 Program directors were asked to indicate how reentering physicians found their programs.
44 Seventeen percent of program directors said "medical association;" 33% stated "colleague;" 67%
45 stated that physicians found them through the internet/program web site; 83% stated medical board
46 and 33% replied "other." Program directors stated that "hospital medical staff office" and
47 "physician's attorney" were other ways physicians found out about reentry programs.

48
49 Program directors were also asked to identify how physicians are referred to the program. All 6
50 programs stated that physicians were referred to them from hospital credentialing committees, state

1 medical boards, or from self-referrals. One program director listed “referral from other assessment
2 programs” as another way reentering physicians are referred to the program.

3
4 Criteria for Program Acceptance

5
6 Program directors gave a variety of criteria for acceptance into the physician reentry programs. For
7 example, physicians must: be in good standing, return to the same area/scope of practice, have a
8 medical license or a permit from their board, and be out of practice for a limited time period (e.g.,
9 no longer than 10 years).

10
11 Final Assessment of Program Participants

12
13 About two-thirds (67%) of programs have a final assessment at the completion of the programs; all
14 programs document successful program completion through a letter or summary document.

15
16 Barriers to Program Access

17
18 Program directors were asked, “What barriers do you think exist for physicians trying to access the
19 physician reentry program?” Two-thirds (67%) stated that money/financial issues were a barrier.
20 Other barriers program directors’ reported were: lack of guidelines/standards of regulation,
21 licensure, lack of confidence, travel and being away from family, and ability to obtain a local
22 preceptor.

23
24 Remediation Services

25
26 The AMA defines physician remediation as: The process whereby deficiencies in physician
27 performance identified through an assessment system are corrected (CME Report 3, A-09.)
28 Program directors were asked two questions with regard to remediation: 1) Does the program
29 provide services to physicians who need remediation? and 2) If yes, are these services the same as
30 or different from the services provided to physicians seeking reentry?

31
32 All of the programs provided remediation services as well as reentry services. Half of the
33 programs provided remediation services that were the same as services for reentry while the other
34 half provided remediation services that were different from their reentry services. Differences
35 included individualized curricula and competence assessment.

36
37 AMA Guiding Principles

38
39 The AMA CME developed the 10 guiding principles for a physician reentry program system
40 (included in the Appendix). Program directors were asked to rank the importance of each guiding
41 principle to the physician reentry program. The Appendix shows the number of program directors
42 who selected each option and the percent of the total program directors who selected each option.

43
44 At least half (50% – 87%) of program directors indicated that all of the guiding principles were
45 either “Very Important” or “Important.” The two guiding principles which garnered the largest
46 support were: Flexible-to maximize program relevancy and usefulness (87%) and Innovative-to
47 meet the diverse and changing needs of reentering physicians (87%).

48
49 A main implication of the perceived importance of the guiding principles by program directors is
50 that these guiding principles can be used by future physician reentry programs as a basis for
51 developing model program standards.

1 DISCUSSION

2
3 Facilitating physician reentry to practice continues to be an important issue for the medical
4 profession. However, the surveys described in this informational report indicate that there are
5 many barriers to physician participation.

6
7 *Lack of Information About Need*

8 There is a lack of data on the number of physicians who would participate in a reentry program if
9 the barriers described below were removed. This lack of information about need limits the ability
10 to plan for program development.

11
12 *Ease of Access*

13 Programs are not geographically accessible to many physicians, who would have to travel to
14 participate. The availability of regional training sites could ease this barrier.

15
16 *Liability and Credentialing Issues*

17 In order for physicians to participate fully in reentry programs, they need access to clinical training
18 sites. This access can be hampered by credentialing issues, as well as by lack of access to liability
19 protection for themselves and their supervisors.

20
21 *Funding Constraints*

22 The major source of funding for reentry programs is fees paid by participants. These costs may be
23 prohibitive for physicians without a source of income. In addition, lack of convenient access to
24 programs requires that physicians travel or re-locate, which adds costs.

25
26 *Lack of Consistency in Regulatory Guidelines*

27 Many state medical licensing boards now either have a reentry policy or are in the process of
28 planning or developing one. However, states are independently developing these regulations and
29 processes. The lack of consistency across geographic boundaries may make reentry harder for
30 physicians.

31
32 States also vary in their definition and criteria for maintaining an active medical license. While
33 some physicians who have taken a hiatus from clinical practice may seek opportunities to update
34 their skills before caring for patients, there is evidence that others with active medical licenses may
35 return to practice without obtaining reentry services.⁵ While not all physicians may need to update
36 their skills before reentering practice, the current structure of the licensure system may be
37 preventing medical regulatory bodies from making that assessment.

38
39 *Lack of Certification Related to Program Completion*

40 While reentry programs typically document program completion, not all include a final assessment
41 that would assure that physicians completing the program have achieved the expected outcomes.
42 The lack of a documented outcome may make credentialing the physician more difficult as he/she
43 attempts to return to practice.

44
45 In collaboration with other stakeholder groups, for example, our long-standing relationship with the
46 American Academy of Pediatrics, our AMA will continue to maintain visibility and leadership in
47 the area of physician reentry. This includes supporting the creation of consistent regulatory
48 guidelines for reentry and assisting programs in adopting the AMA's 10 guiding principles for a
49 physician reentry program system.

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APPENDIX
Importance of Guiding Principles to Physician Reentry Programs

Guiding Principles	Very Important	Important	Moderately Important	Of Little Importance	Unimportant
Accessible (by geography, time and cost)	1 17%	3 50%	1 17%	1 17%	0 0%
Collaborative (to improve communication and resource sharing)	2 33%	2 33%	1 17%	0 0%	1 17%
Comprehensive (to maximize program utility)	3 50%	1 17%	0 0%	1 17%	1 17%
Ethical (based on accepted principles of medical ethics)	4 67%	0 0%	0 0%	0 0%	2 33%
Flexible (to maximize program relevancy and usefulness)	3 50%	2 33%	0 0%	0 0%	1 17%
Modular (tailored to the learning needs of reentering physicians)	3 50%	1 17%	1 17%	0 0%	1 17%
Innovative (to meet the diverse and changing needs of reentering physicians)	2 33%	3 50%	0 0%	0 0%	1 17%
Accountable (has mechanisms for assessment and open to evaluation)	3 50%	1 17%	0 0%	0 0%	2 33%
Stable (to ensure financial stability over the long term)	2 33%	2 33%	1 17%	0 0%	1 17%
Responsive (able to make refinements and updates as well as address systemic changes including regulatory)	3 50%	2 33%	0 0%	0 0%	2 33%

The Appendix shows the number of program directors who selected each option and the percent of the total program directors who selected each option.