HOD ACTION: Council on Medical Education Report 6 adopted as amended and the remainder of the report filed.

REPORT 6 OF THE COUNCIL ON MEDICAL EDUCATION (A-08)
Physician Reentry
(Reference Committee C)

EXECUTIVE SUMMARY

Data and anecdotal information from physicians indicate that the need for physician reentry programs is increasing and that this trend is likely to continue. The changing demographics of the physician workforce is a key factor contributing to this need. Women now comprise a larger percentage of the physician workforce than ever before. Data from the Association of American Medical Colleges (AAMC) show that almost half (49.1%) of medical graduates in academic year 2006-2007 were women, as compared to two decades earlier when women comprised less than one-third (30.8%) of medical graduates. Women are more likely than their male counterparts to take time off during their careers to attend to family responsibilities. Reentry is not an issue exclusive to women, however. Studies show that reentry is relevant to both men and women.

This report will 1) discuss the need for and barriers to physician reentry programs; 2) define reentry and related terms; 3) provide information on existing physician reentry programs in the United States; 4) discuss state reentry guidelines; 5) present alternatives to reentry; 6) provide information on the work by key organizations on the issue of reentry; and 7) present priorities and next steps and offer recommendations. Also, a set of Guiding Principles has been developed for this report. The purposes of the Guiding Principles are to reflect the values and beliefs underlying physician reentry and provide direction as the process of developing a physician reentry program (PREP)* system moves forward.

The Council on Medical Education recommends that our American Medical Association take the following actions:

1. That our AMA continue to collaborate with other appropriate organizations on physician reentry issues including research on the need for and the effectiveness of reentry programs.
2. That our AMA 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. That our AMA support efforts 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. That our AMA support efforts to ensure the affordability and accessibility, and to address the unique liability issues related to PREPs.
5. That our AMA make available to all interested parties the physician reentry program (PREP) system Guiding Principles for use as a basis for all reentry programs.
6. That our AMA, as part of its Initiative to Transform Medical Education strategic focus and in support of its members and Federation partners, develop model program standards utilizing PREP system Guiding Principles with a report back at the 2009 Interim Meeting.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 6 - A-08

Subject: Physician Reentry

Presented by: Richard J.D. Pan, MD, MPH, Chair

Referred to: Reference Committee C
(David M. Lichtman, MD, Chair)

Introduction

Resolution 316 (A-06), submitted by the Young Physicians Section and adopted as amended, asked that our American Medical Association (AMA) in collaboration with appropriate state and specialty societies, the Accreditation Council on Graduate Medical Education (ACGME), the American Board of Medical Specialties (ABMS), and the Federation of State Medical Boards (FSMB):

> Study the issue of physician reentry in clinical practice after leave of absence from practice or a limitation of certain aspects of practice, including a consideration of issues related to retraining, certification, and credentialing; and that the proposed AMA study on physician reentry into practice also assess the overall impact of reentry issues on the physician workforce.

Reference Committee C heard positive testimony on Resolution 316. There was support for studying physician reentry because of the numbers of physicians who take a leave of absence from their practices for varied reasons and have no information or knowledge of the requirements for reentry or how to access reentry programs. Workforce implications and the need to identify the number of physicians who might need reentry programs were issues emphasized by those testifying. It was noted that the Federation of State Medical Boards (FSMB) had expressed strong interest in this issue and had offered to participate with the AMA in this endeavor.

This report will 1) discuss the need for and barriers to physician reentry programs; 2) define reentry and related terms; 3) provide information on existing physician reentry programs in the United States; 4) discuss state reentry guidelines; 5) present alternatives to reentry; 6) provide information on the work by key organizations on the issue of reentry; and 7) present priorities and next steps and offer recommendations. Also, a set of Guiding Principles have been developed for this report. The purposes of the Guiding Principles are to reflect the values and beliefs underlying physician reentry and provide direction as the process of developing a physician reentry program (PREP) system moves forward.

For the purposes of this report, the AMA has drawn from the important work of the American Academy of Pediatrics (AAP) Physician Reentry into the Workforce Project. The AMA has also obtained information and sought perspective from those in medical education with expertise in the issue of physician reentry including academics, researchers, and administrators.

The subject of physician reentry often includes the related issues of physician retraining and remediation. While the AMA recognizes that many physicians seeking reentry, retraining and remediation have similar circumstances, each issue is distinct. Therefore, the Council on Medical Education plans to prepare reports on remediation to address issues pertaining to physicians who have received disciplinary action or are impaired and retraining to address issues regarding physicians who desire to change practice and specialty in the near future.

There is often a negative perception about physician retraining and remediation because these terms have traditionally been associated with physicians who have been disciplined and/or have been mandated to seek further training because of gaps in knowledge or skill, although retraining is also defined as learning the necessary skills to move into a new clinical area such as a new specialty. Reentry however, is used for physicians in good standing and is related mainly to issues such as length of time away from practice (see Appendix 1 for a list of terms and definitions).

For the purposes of this report, physician reentry is the focus and is defined 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.*

Scope of the Issue

The issue of physician reentry is of direct concern to physicians, patients and the public. A well-designed PREP system allows physicians who have been away from clinical practice a means to return to clinical activity while simultaneously maintaining high quality care by ensuring that physicians are current and proficient in their chosen area of practice. Additionally, a PREP system has the potential to address key workforce issues such as assuring that competent physicians are not lost to the workforce, allowing relocation, and permitting restriction of practice including dropping high risk procedures.

Data and anecdotal information from physicians indicate that the need for physician reentry programs is increasing and that this trend is likely to continue. The changing demographics of the physician workforce is a key factor contributing to this need. Women now comprise a larger percentage of the physician workforce than ever before. Data from the Association of American Medical Colleges (AAMC) show that almost half (49.1%) of medical graduates in academic year 2006-2007 were women, as compared to two decades earlier when women comprised less than one-third (30.8%) of medical graduates. Women are more likely than their male counterparts to take time off during their careers to attend to family responsibilities. Reentry is not an issue exclusive to women, however--studies show that reentry is also relevant to men.

There are many reasons why a physician might take a leave of absence from clinical practice including family leave (maternity and paternity leave, and child rearing), other caretaking and relationship issues, personal health reasons, career dissatisfaction, alternate careers such as administration, military service, and humanitarian leave. Physicians may seek reentry to practice when their need to care for family is not as immediate or when their health improves. For example, physicians may also miss caring for patients after changing careers or retiring. Findings from one

study in North Carolina show that between 2003 and 2004, 94 physicians moved from inactive to active instate practice and 47 physicians moved from retired status to active instate practice. Findings from a study of Arizona physicians who renewed their medical licenses between 2003-2006 indicate that among 13,215 licensed physicians, 604 or 4.6% reentered clinical practice.

More studies are needed to assess the need for reentry programs including the number of physicians who would consider returning to practice should the opportunity for reentry exist. An in-depth examination of need may also include information on physician competency to provide care after time away from practice and on what competencies might decay over time while others remain in force.

Despite the increasing demand for physician reentry programs, there are a number of barriers that make it difficult or prohibitive for physicians to return to clinical practice. Regulations set by states for regaining a license and by health care institutions for maintenance of credentials are an important barrier to reentry. Research has found that lack of access to PREP programs is a significant barrier that impedes physicians' reentry into practice. Lack of access hinges primarily on the fact that there are so few reentry programs. Limited support and financing for reentry programs within the medical profession and within health care institutions is also a contributing factor. Physicians wanting to participate in reentry programs also confront a dearth of available information on programs. There is currently no comprehensive database which provides physicians with information on reentry programs such as the structure, requirements, and outcomes of programs. Other barriers include: associated costs, such as the need to move to another site to participate in programs, and the cost of medical liability insurance. Reentry programs may be very time consuming. There is a lack of standardized curricula, and no officially recognized accreditation process for reentry programs.

Physician Reentry Programs in the United States

A main goal of reentry programs is to assure that physicians have retained their clinical competence or to enhance, broaden, and/or develop clinical medical skills. Successful completion of a physician reentry program allows physicians to return to active clinical practice after an extended leave.

Four physician reentry programs or initiatives have been identified within the United States. These programs use a variety of "teaching" methods including shadowing, mini-residency, and part-time supervised experience, often utilizing a combination of these methods. See Table 1 for a list and brief descriptions of the programs.

State Reentry Guidelines

While the range is from 1-5 years, in most states, physicians who take a leave of absence from practice for a period of 2 or more years are recommended to participate in a physician reentry program before returning to clinical practice. North Carolina has taken the lead in developing guidelines applicable to physicians who want to reenter clinical practice through the passage of House Bill 1301, which was signed into law (2006-144) July 19, 2006. Section 4 of the law, which took effect on October 1, 2006, gives the State Medical Board authority to, among other things, "require satisfactory completion of…educational training" for physicians who have not "actively practiced medicine…or maintained continued competency, as determined by the Board" for a

period of two years. For a copy of the law see: http://www.ncga.state.nc.us/Sessions/2005/Bills/House/HTML/H1301v5.html.

The AMA has been collecting data on reentry guidelines and requirements from state medical licensing boards. To date, the response rate is insufficient to draw any conclusions. This work is ongoing, however, and will be used to inform the AMA's efforts in this area.

Proposed Guiding Principles

The Council on Medical Education (CME) of the AMA recommended the development of a set of guiding principles for a physician reentry program (PREP) system. A well-designed PREP system should be consistent with the current continuum of medical education and meet the needs of the reentering physician. An underlying assumption is that physicians do not necessarily lose competence in all areas of practice with time. There are competencies, such as patient communication, and professionalism, that may not decay. Therefore, it is anticipated that reentry programs will target areas where physicians are more likely to have lost relevant skills or knowledge, or where skills and knowledge need to be updated.

The guiding principles of a PREP system must reflect the values and beliefs underlying the profession. Guiding principles provide direction and serve as a reference for setting priorities and standards for action. Further, these guiding principles serve as a foundation from which programs can be planned, evaluated and monitored.

The following are ten suggested guiding principles for a PREP system. The Council developed proposed guiding principles with extensive feedback from members of the AAP Reentry into the Workforce Project, as well as feedback from other experts in medical education and literature review.

1. *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.

2. *Collaborative: The physician reentry program 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.

3. *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.

4. *Ethical: The PREP system is based on accepted principles of medical ethics.* Physician reentry programs will conform to physician licensure statues. The standards of professionalism, as stated in the AMA *Code of Medical Ethics*, must be followed.

5. *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.

6. *Modular: Physician reentry programs are modularized and individualized*. 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.

7. *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.

8. *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 exists across programs to assess whether or not national standards are being met.

9. *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.

10. *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.

<u>Strategies for Bypassing Reentry</u>

The purpose of this section is to discuss ways to bypass the need for participation in the formal process of physician reentry programs. Physicians considering taking a leave of absence from clinical practice may want to consider the value of remaining partially clinically active. This allows physicians to maintain current medical knowledge and practice skills and thus, the ability to provide competent, safe patient care. By remaining clinically active to some degree, physicians may reduce or eliminate their need for reentry programs and regaining licensure.

Working part-time may be one viable option for remaining clinically active. There is evidence that many physicians are working part time at some point during their careers. Volunteering at a free clinic is another option, shared practices is another. The AAP Committee on Pediatric Workforce (COPW) Subcommittee on Women in Pediatrics collaborated with the AMA Women Physicians Congress (AMA-WPC) Governing Council to informally survey 511 physicians and found that 40 percent had worked part-time. Working part-time may be difficult, however. When the AMA Women Physicians Congress asked its members about barriers associated with part-time work, the top four barriers identified were: "loss of income," "loss of benefits," "negative effect on professional success," and "negative effect on future growth." Additionally, the FSMB in its draft report on Maintenance of Licensure (MOL) (see next section) recommends physicians participate in ABMS Maintenance of Certification (MOC) or American Osteopathic Association (AOA) equivalent activities to keep current.

<u>How Other Organizations (AAP, ABMS, FSMB) are Addressing Physician Reentry</u>

Other organizations are addressing the issue of physician reentry as described below.

American Academy of Pediatrics (AAP)

The AAP coordinates the multi-organization Physician Reentry into the Workforce Project. The AMA has a strong presence in the Project through its active participation in the Project's four workgroups: (1) Assessment and Evaluation; (2) Education; (3) Credentialing, Licensure, and Maintenance of Certification; and (4) Workforce.

Other activities of the Physician Reentry into the Workforce Project include collaborating with the AAMC, AMA, and other medical associations to field a cross-sectional survey focused on work patterns for physicians 50 years and older. The survey has generated data on the exiting and reentry patterns of pediatricians over 50. Also, the AAP Division of Graduate Medical Education & Pediatric Workforce conducted a series of three invitational conference calls in September and October 2006 to develop a multi-organizational agenda for physician reentry into the workforce. Currently, the AAP is conducting the Physician Reentry into the Workforce survey. This secondary analysis of data from the AMA Physician Masterfile is being conducted to assess the need for reentry programs by identifying physicians not currently in practice. For a complete description of the AAP Physician Reentry into the Workforce Project, please refer to the web site: http://www.aap.org/reentry/.

American Board of Medical Specialties (ABMS)

Many state medical boards recommend that a physician who has been out of practice for 2 or more years participate in a physician reentry program. This cut-off of 2 years (or 24 months) was developed and recommended by the ABMS as described below.

The ABMS has redefined terms associated with a physician's clinical active status to better indicate a physician's participation in patient care activities. This change applies to guidelines for physician reentry and procedures for public reporting. Following the recommendations of the Maintenance of Certification Task Force, a designation of "clinically active" refers to any amount of direct and/or consultative patient care that a physician has provided in the preceding 24 months. "Clinically inactive" describes a physician who has provided no direct and/or consultative patient

care in the past 24 months. Information on clinical activity status is self reported by the diplomats to their certifying board(s) and is made available to the public by the Member Board.

Federation of State Medical Boards (FSMB)

In 2003, the FSMB established the Special Committee on Maintenance of Licensure to study the issue of state medical boards' role in ensuring physicians' continued competence and to develop recommendations for use by state medical boards. The Committee has prepared a draft report for wide comment regarding how to implement maintenance of licensure requirements. Section two of the draft report provides guidelines which are intended to help the state medical boards facilitate a physician's reentry to practice while simultaneously ensuring the public is protected. The AMA has commented on the draft report, emphasizing that loss of competence in all areas should not be assumed following a period of clinical activity. The draft report will be more formally acted upon at the FSMB's 2008 meeting. More information can be found on the FSMB web site at: http://www.fsmb.org/.

The FSMB, along with 16 other organizations including the AMA, is part of the Coalition for Physician Enhancement (CPE). The overall mission of CPE is to support and develop expertise in personalized assessment, education and enhancement of physicians, in order to promote excellence in patient care. The focus of CPE has been assessment issues related to physicians who are not in good clinical standing. Assessment of physicians in good clinical standing who are seeking to reenter clinical practice is beginning to be considered.

<u>Priorities and Next Steps</u>

Physician reentry into clinical practice is fast becoming an issue of central importance. While few empirical studies on this issue have been conducted, existing data show that increasing numbers of physicians are taking a leave of absence from practice at some point during their careers and this trend is expected to continue. This is due in part to the larger percentage of women in medicine; however, data supports the relevance of reentry to men as well. To prepare for meeting the needs of physicians, the priorities and next steps in the study of physician reentry into clinical practice should be established. Key questions related to the development of reentry programs must be considered. There have been discussions about convening a joint AMA and AAP conference on physician reentry where stakeholders will discuss these issues including questions such as:

- Is the two year timeframe for clinical inactivity appropriate to indicate a need for reentry?
- Which specialties and types of practice patterns are most often in need of reentry?
- What is the evidence that clinical competence decays or in turn, remains intact, during inactivity?
- What elements of competence decay and at what rates?
- How many physicians need to participate in reentry programs?
- How does the structure of a reentry program create an incentive or disincentive to participate?
- How does the profession build good programs that will meet the needs of the reentering physician?
- What professional alliances and partnerships will be needed to support good and available programs?

- What is the cost of creating a comprehensive reentry system, for the individual physician and for the profession as a whole?
- How will programs be financed and what clinical and support resources will be needed?
- What assessment tools, evaluation tools and teaching tools exist that are reliable, valid, flexible but standardized?
- How will reentry programs balance generalized knowledge deficits with individualized educational needs? How will different geographic or specialty standards of care be incorporated?
- How does a physician find a suitable reentry program that is relevant to their practice type, affordable, and flexible?
- How will physicians' need for a structured, coordinated physician reentry system be balanced against their need for tailored, individualized educational approaches within reentry programs?
- What regulations are needed to set the criteria for these programs and how will they be determined?

RECOMMENDATIONS

The Council on Medical Education recommends that the following be adopted and the remainder of the report be filed.

1. That our American Medical Association continue to collaborate with other appropriate organizations on physician reentry issues including research on the need for and the effectiveness of reentry programs. (Directive to Take Action)

2. That our AMA 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. (Directive to Take Action)

3. That our AMA 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. (Directive to Take Action)

4. That our AMA support efforts to ensure the affordability and accessibility, and to address the unique liability issues related to PREPs. (Directive to Take Action)

5. That our AMA 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 statues. 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. (Directive to Take Action)

6. That our AMA, as part of its Initiative to Transform Medical Education strategic focus and in support of its members and Federation partners, develop model program standards utilizing PREP system Guiding Principles with a report back at the 2009 Interim Meeting. (Directive to Take Action)

Fiscal Note: $30,000 to convene a conference and conduct research.

Complete references for this report are available from the Medical Education Group.

Note: For purposes of this report only, and for ease of reference within this report, an acronym has been used in place of the phrase "physician reentry program" but the AMA is not thereby asserting any claim to, nor does it intend to infringe, any interests of other parties in PREP.

Appendix 1: Definition of Terms

The definitions for the terms listed below were adapted from the AAP Physician Reentry into the Workforce Project, the FSMB draft report on Maintenance and Licensure and literature review.

Definition of Terms

In this and future reports, the following definitions will be used.

Impaired Physician: A physician who is unable to fulfill personal or professional responsibility because of psychiatric illness, alcoholism or drug dependency.

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.

Physician Reentry Program (PREP): Structured curriculum and clinical experience which prepares physicians to return to clinical practice following an extended period of clinical inactivity.

Physician Reentry Program (PREP) System: Provides a way of organizing and planning physician reentry programs.

Physician Retraining: The process of updating one's skills or learning the necessary skills to move into a new clinical area.

Remediation: The process whereby deficiencies in physician performance identified through an assessment system are corrected.

Table 1: Physician Reentry Programs in the United States

Name (Start Date)	Location	Purpose	Plan of Study	Eligibility	Cost	Contact
Center for Personalized Education for Physicians (CPEP), Clinical Practice Reentry Program (1990)	Denver, CO	The main purpose of CPEP is to provide the in-depth information and educational solutions needed to objectively address physician performance concerns. CPEP, however, also helps evaluate clinical competence of a physician who has been out of practice for an extended period.	Physicians complete coursework in Denver and return home for 3 to 9 months of clinical work, which is set up with a local physician mentor.	Physicians who left the field of medicine in good standing and who plan to reenter areas of clinical practice in which they have had prior clinical training and experience.	$5,500-$7,500	http://www.cpepdoc.org/re-entry-program.cfm
The Interinstitutional Physician Reentry Program (IPRP)	Oregon Health & Science University (OHSU), Portland, OR	To refresh skills previously mastered by the physician after a period of time out of practice for family or personal reasons; NOT designed to train physicians in new skills or to provide mandated remediation after issues with substance abuse, malpractice, unprofessional behavior, etc. The program has most experience with OBGYN retrainees but has also retrained internal medicine subspecialists and pediatricians.	For a period of several months, physicians are integrated into individualized fellowships within the graduate medical education structure. Physicians also participate in rounds, see patients and do surgery under the supervision of attending physicians.	Physicians who have successfully completed an accredited US residency program.	$2,500-$10,000 per month plus application fee of $1,500.	OHSU Division of CME: 503-494-8700

Table 1: Physician Reentry Programs in the United States (Continued)

Name (Start Date)	Location	Purpose	Plan of Study	Eligibility	Cost	Contact
ReMed@Drexel (2006)	Drexel University, Philadelphia, PA	To give physicians resources to enhance their professional and clinical skills.	There are three program modules which may be taken in sequence or independently. The program offers a six week internal medicine preceptorship as well as tracks in OBGYN, surgery, and pediatrics.	Physicians who wish to return to active clinical practice after an extended leave, physicians who wish to change their specialty focus and need a primary medical update, international medical graduates who wish to be accepted into U.S. graduate medical education training programs, and physicians who wish to enhance their clinical skills.	$7,500 – $8,500 per module.	http://webcampus.drexelmed.edu/refresher/default.asp
Physician Reentry Project	John Peter Smith Health Care Consortium, Fort Worth, TX	This program is set to launch in April 2008. The first physicians to participate will be family physicians, however, the program will be open to all specialties.	During a three month time period, physicians are given an assessment and an Individualized Educational Plan. Physicians then participate in a mini residency after which they are evaluated. Then, for one year, physicians participate in redactive chart review.	Physicians in good standing.	$20,000-$30,000 for the entire program.	

Note: Drexel University, John Peter Smith Health Consortium and Oregon Health and Science University are collaborating on their physician reentry programs. The intent is to be able to collect data and make comparisons across programs.