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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INTRODUCTION

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

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

> "Consider creating alternatives to the current sequence of medical education continuum, including introducing options so that physicians can re-enter or modify their practice."[1]

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

- 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 retraining: The process of updating one's skills or learning the necessary skills to move into a new clinical area (CME Report 6 (A-08.)

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

THE EVOLUTION OF THE CONCEPT OF "REENTRY"

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

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

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

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

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

SUMMARY OF FINDINGS FROM TWO SURVEYS ON PHYSICIAN REENTRY

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

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

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

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

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

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

Patient Care Requirements for Relicensure

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

Survey 2: Physician Reentry Program Questionnaire

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

Program Demographics

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

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

Program Participants

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

Finding Programs and Referrals

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

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

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

Criteria for Program Acceptance

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

Final Assessment of Program Participants

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

Barriers to Program Access

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

Remediation Services

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

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

AMA Guiding Principles

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

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

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

DISCUSSION

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

Lack of Information About Need

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

Ease of Access

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

Liability and Credentialing Issues

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

Funding Constraints

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

Lack of Consistency in Regulatory Guidelines

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

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

Lack of Certification Related to Program Completion

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

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

REFERENCES

1. American Medical Association (June, 2007). Initiative to Transform Medical Education: Recommendations for change in the system of medical education. Available on-line at: http://www.ama-assn.org/ama1/pub/upload/mm/16/itme_final_rpt.pdf

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3. Croasdale, M. (2007). Clinical retraining programs hard to find. amednews.com. Available on-line at: http://www.ama-assn.org/amednews/site/free/prsa0604.htm

4. Mark, S. & Gupta, J. (2002). Reentry into clinical practice: Challenges and strategies. JAMA, 288(9), 1091-1096.

5. American Academy of Pediatrics (n.d.). AMA Masterfile Survey. Available on-line at http://www.aap.org/reentry/reentry_issuebrief2_final.pdf

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.