

PHYSICIAN REENTRY THEMES & OPPORTUNITIES

PHYSICIAN REENTRY INTO CLINICAL PRACTICE CAN BE DEFINED AS RETURNING TO PROFESSIONAL ACTIVITY/CLINICAL PRACTICE FOR WHICH ONE HAS BEEN TRAINED, CERTIFIED OR LICENSED AFTER AN EXTENDED PERIOD OF ABSENCE. THIS IS AN ISSUE THAT CUTS ACROSS GENDERS AND SPECIALTIES.

Introduction

In June of 2014 the American Medical Association (AMA) Council on Medical Education hosted a stakeholder’s session, “Re-Entry to Medical Practice: Defining the Needs for Medical Education.” During this session the AMA Council on Medical Education engaged stakeholders from diverse organizations in a discussion of how to address the challenges of reentering clinical practice and how to meet the needs of physicians reentering clinical practice. An outcome of this session was the identification of the following 8 reentry themes.

Reentry is an important topic for many stakeholders

Reentry continues to be an important topic of discussion for many stakeholders (i.e. physicians, specialty societies, medical schools, medical boards, regulatory agencies and those involved with specialty certification/Maintenance of Certification). Specialty and state regulatory boards have a vested interest in the continued competence of physicians who leave and later reenter clinical practice, and how these physicians can maintain and demonstrate clinical competence in their profession. In addition, concerns around the capacity of the physician workforce and possible physician shortages has brought medical schools and others to the discussion regarding possible ways that reentering physicians might help lessen shortages and increase capacity.

Reentry crosses all specialties and genders

Both surveys and anecdotal evidence support the idea that physician reentry is an issue that crosses all medical specialties and genders. In fact results from a national study conducted by The Physician Reentry into the Workforce Project and using AMA Masterfile data found that 50.4% of reentry physicians were female and

49.6% were male.¹ This same survey also found that for both men and women the top reasons for being inactive or leaving clinical practice were personal health issues and structure and practice of medicine issues (“hassle factor”, malpractice premiums, lack of professional satisfaction etc.). Both female and male physicians reported diverse reasons that might lead them to go back to clinical practice. For women the availability of part-time work and/or flexible work schedules had a strong influence on considering going back to clinical practice.

There is a need for data on reentry physicians and those currently out of clinical practice

“How many reentry physicians are out there?” This is a question that is asked almost any time physician reentry is discussed. The only national survey of physicians and physician reentry (discussed above) did not allow for credible stratification by specialty.

Reentry efforts should move forward despite lack of data

The lack of data on the numbers of reentry physicians has been a barrier to getting individuals and organizations to embrace both the concept of physician reentry and the need to assist these physicians. The cost and time involvement of national surveys, such as the one mentioned above, may be one of the reasons why this research has not been repeated.

There has been some movement forward in data collection. One such example is that in 2012 the Federation of State Medical Boards (FSMB) adopted a minimal dataset policy, which recommends that licensing boards include workforce questions as part of its license renewal process for physicians. As part of this work, a 2011 survey found that approximately half of all licensing boards indicated they collected at least some physician workforce data that includes information such as number of hours worked, practice location and full-time vs. part-time work. Although answering these questions is typically voluntary, collection of this information may be helpful in determining the number of potential reentry physicians.

In addition, there have been several published studies that look at physician reentry through the narrow lens of a specific program, specialty or a specific geographic area.² Despite the lack of firm data on the number of reentry physicians and the demand for reentry services, efforts to assist these individuals should move forward as the demand for reentry services, will depend, at least in part, on the perceived availability and feasibility of reentry programs.

Explore the differences and similarities of retraining, remediation, and reentering

¹ Jewett EA, Brotherton SE, Ruch-Ross H. A National survey of ‘inactive’ physicians in the United States of America: enticements to reentry. *Human Resources of Health* 2011;9:7 (17 February 2011).

² <http://www.physician-reentry.org/resources/reentry-physicians-reading-list/>

The resources a physician seeks in order to reenter clinical practice after a voluntary leave of absence, remediation, or retraining are often the same, though applied at different levels of intensity. Some reentry programs have grown out of already established programs that provide physician assessment and evaluation services for other issues (e.g., remediation, retraining). It may be worthwhile to consider how these programs may be used to help determine the demand for reentry resources as well as how these programs can help meet the needs of reentry physicians.

Developing reentry services and programs is challenging

The development of reentry programs and services has its own set of challenges, including but not limited to, funding sources, an educational culture that may inhibit development of programs, standardization of programming and assessment, and programming that cannot be a one-size-fits-all approach to meet the needs of the reentry physician. As noted above, some reentry programs have developed out of already established programs; this can help defray the costs associated with developing and maintaining stand-alone reentry programs.

Additionally, while many current reentry programs are highly regarded, there is not a single model for reentry programs, and they are not subject to either standard requirements or external evaluation. The costs to participate in these programs can also be a significant barrier to physicians. Finally, the limited availability of programs to physicians and the variability in what programs may be able to offer to other interested stakeholders (medical boards, hospitals, malpractice insurers, etc.) can be challenging as well.

Need for robust communication

It is not uncommon for physicians to leave clinical practice for a period of time during their career and then seek to reenter clinical practice. In fact, many believe leaving and reentering the clinical workforce should be regarded as a normal part of a physician's career path. The concept and implications of leaving clinical practice and the requirements and challenges in returning needs to be communicated to the physician community so that physicians can plan accordingly. The implications and challenges of reentry to clinical practice also needs to be communicated to the stakeholders noted in the first theme of this Briefing Sheet, and to others who have a vested interest in the continued competence of physicians and the safety of patients.

Working together is key

The demand for reentry programs and services for clinically inactive physicians will continue. There also continues to be barriers and challenges to reentry. Determining how to best meet the needs of physicians seeking to reenter clinical practice will take working together by all of the key stakeholders including physicians, regulatory boards, state and medical specialties, insurers, medical schools and others.

Next Steps

1. Provide a platform for continued information sharing and dissemination of information on physician reentry issues including research and data collection, reentry program information and other related activities. This may include web sites such as www.physicianreentry.org which serves as a non-specialty specific clearinghouse of information from organizations and programs.
2. Encourage the sharing of information on the importance of planning ahead of time for a leave from clinical practice in a wide range of venues including, conferences, state and specialty society communications, medical and specialty board communications, and medical education and continuing medical education programs. Encourage the development and sharing of career planning materials (especially on non-clinical careers) to physicians.

AMA Council on Medical Education “Re-entry to Medical Practice: Defining the Needs for Medical Education” Panelists:

- Humayun Chaudhry, DO, Federation of State Medical Boards
- Jeffrey Gold, MD, AMA Council on Medical Education
- Eileen Handberg, PhD, University of Florida College of Medicine
- Richard Hawkins, MD, American Medical Association
- Mira Irons, MD American Board of Medical Specialties
- Norman Kahn, MD, Council on Medical Specialty Societies
- William McDade, MD, AMA Council on Medical Education
- Holly Mulvey, MA, American Academy of Pediatrics
- Robert Steele, MD, Coalition for Physician Enhancement

This Briefing Sheet was created by the by The Physician Reentry into the Workforce Project in collaboration with the American Medical Association. For more information on The Physician Reentry into the Workforce Project visit www.physicianreentry.org

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