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Medical education and re-entry: Finding ways to re-educate the physician who wants to come back to clinical practice

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Abstract: As physicians narrow their scope of practice, take on non-clinical roles or just take time off for personal reasons, a problem has developed for academic and accrediting bodies on how best to determine competency upon a return to a clinical role or expand the scope of practice. Currently in the US there are areas of physician shortages, and there is an estimated shortfall of 12,500–31,000 primary care physicians by 2025 (http://www.who.int/mediacentre/news/releases/2015/partnership-primary-health-care/en/). Many physicians are involved in maintenance of certification, state licensure requirements and meaningful use regulations in order to maintain the ability to practice clinical medicine. A licensed physician who is inactive must simply re-register (http://www.aafp.org/news/practice-professional-issues/20150303aamcwkforce.html), however, more and more institutions are refusing to credential physicians with a gap in clinical practice. According to the Federation of State Medical Boards (FSMB), “It is important for the physician to understand that medical licensure renewal is based on continuing professional development even if taking a leave from clinical practice and the burden of proof is on the physician to show that he or she has met the appropriate requirements for licensure” (https://download.ama-assn.org/resources/doc/med-ed-products/x-pub/

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Both authors have served individually as president of the New York State Academy of Family Physicians. They have published and presented nationally and internationally on a myriad of subjects. They have been involved in the evolution of physician education and quality and the requirements for consistent re-entry programs. Their research into this topic has been a collaborative effort for over two years.

PUBLIC INTEREST STATEMENT

How do we make sure that the physician who has taken time off from practicing medicine, still has the appropriate skills to care for patients? This is the dilemma that many doctors, health care facilities and licensing organizations are struggling with. Physicians have many reasons for taking a break from clinical practice, ranging from working exclusively in an administrative role to taking time off for family or health issues. Regardless of the cause, there is a need for a systematic process to allow physicians to re-enter the clinical realm. This re-entry process requires an educational platform that is accessible to physicians of various specialties and regions, with an appropriate funding source along with external checks and balances. This article explores what has been done within the medical education arena for re-entry and poses questions as to what should be done in the future to ensure patient safety.

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physician-reentry-regulations.pdf). There are many re-entry processes in the academic arena. It can be via a universities, medical societies, state medical boards or private organizations; however, creating a national reentry program will require looking to numerous funding sources (http://www.aafp.org/news/practice-professional-issues/20150303aamcwkforce.html). This article explores what has been done within the medical education arena for reentry and poses questions as to what should be done in the future, and by whom.

Subjects: Education; Medical Education; Medicine

Keywords: re-entry; education; medicine; physician; training; family; academic

As physicians narrow their scope of practice, take on non-clinical roles or just take time off for personal reasons, a problem has developed internationally for academic and accrediting bodies on how best to determine competency upon a return to a clinical role or expand the scope of practice. The latest group is physician refugees displaced for an extended period of time and trying to return to clinical practice. According to the World Health Organization (WHO), more than 400 million people worldwide lack access to primary health care (http://www.who.int/mediacentre/news/releases/2015/partnership-primary-health-care/en/). Currently in the US there are areas of physician shortages, and there is an estimated shortfall of 12,500–31,000 primary care physicians by 2025 (http://www.aafp.org/news/practice-professional-issues/20150303aamcwkforce.html). Various countries have differing methods of certifying family physicians. In Canada, graduates of medical schools completed a rotating internship prior to general licensure but this process changed in 1994 so that residents have an educational license and receive a full license upon specialty certification. Family physicians in the US are involved in maintenance of certification, state licensure requirements and meaningful use regulations in order to maintain the ability to practice clinical medicine. A licensed physician who is inactive must simply re-register (https://download.ama-assn.org/resources/doc/med-ed-products/x-pub/physician-reentry-regulations.pdf), however, more and more institutions are refusing to credential physicians with a gap in clinical practice. According to the Federation of State Medical Boards (FSMB), “It is important for the physician to understand that medical licensure renewal is based on continuing professional development even if taking a leave from clinical practice and the burden of proof is on the physician to show that he or she has met the appropriate requirements for licensure” (http://physician-reentry.org/wp-content/uploads/TipsforHandlingInquiriesFINAL.pdf).

There are many ways a re-entry process can play out in the academic arena. It can be via a universities, medical societies, state/national medical boards or private organizations; however, creating national reentry programs requires looking to numerous funding sources (https://download.ama-assn.org/resources/doc/med-ed-products/x-pub/physician-reentry-regulations.pdf). This arti- cle explores what has been done within the international medical education arena for reentry and poses questions as to what should be done in the future, and by whom.

> 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 (http://www.aafp.org/news/practice-professional-issues/20150303aamcwkforce.html).

A 2008 survey sent to almost 5,000 inactive physicians under 65 years from the American Medical Association (AMA) databank showed that almost half had practiced primary care. The main reason for leaving was for personal health, and many returnees wanted part-time or flexible schedules. The majority felt reentry was complex, and of those that attempted the process, 35.9% found it difficult (Jewett, Brotherton, & Ruch-Ross, 2011). According to the PRWP, the barriers to reentry include the physicians themselves (lack of knowledge, educational gaps, fear), extensive state licensure requirements or limited options, hesitation by hospital, insurance or managed care privileging bodies, liability

insurance, prospective employers, and the reentry programs themselves (affordability, flexibility and relevance) (http://physician-reentry.org/wp-content/uploads/IssueBriefRe-EntryBarriers.23782006.pdf). A survey was also carried out in British Columbia involving family physicians and general practitioners to assess their level of interest in reentry training as well as barriers. Similar results were found with regards to the interest being overshadowed by the obstacles to the process. Specific obstacles mentioned included the duration of training, finance, family issues and relocation (Jamieson, Webber, & Sivertz, 2010).

Physicians in the US today are juggling maintenance of certification, state licensure requirements, meaningful use regulations, Joint Commission's Ongoing Professional Practice Evaluation (OPPE) and Focused Professional Practice Evaluation (FPPE). Those who fail to maintain these credentials may find themselves facing reentry issues. For some specialties, like family medicine, the American Board of Family Medicine (ABFM) has its own reentry process for Physicians who have let their certification expire and lapse for more than three years or have never been in the MC-FP process, as does the American Board of Osteopathic Family Physicians (ABOFP). These physicians need to complete this process in order to be eligible for the exam and gain certification status. In many countries, a licensed physician who is inactive must simply re-register (https://download.ama-assn.org/resources/doc/med-ed-products/x-pub/physician-reentry-regulations.pdf), however, more and more organizations are refusing to credential physicians with a gap in clinical practice.

In the United Kingdom, the Academy of Medical Royal Colleges developed a "Return to Practice Guidance" in 2012 (http://www.aomrc.org.uk/doc_view/9486-return-to-practice-guidance) which came from a working group to determine the procedure for doctors returning to practice. They created a checklist of questions recommended pre-absence from clinical practice and post-absence to facilitate planning. They also recommended there be an organizational policy for return to practice at the potential site. For those out of practice for more than 5 years, the General Medical Council (GMC) requires work in an Approved Practice Setting (APS).

Not all countries allow a lengthy period of 5 years. South Africa requires physicians out of practice for over 2 years to undertake supervised practice for a year while participating in continued professional development (CPD) activities, then have routine audits for independent practice. Physicians in Latvia must take an exam after 2 years away from clinical practice (Health Professionals Council of South Africa, 2015).

Allowing more time away is the Medical Board of Australia which has a Recency of Practice registration standard for doctors with absences of one to three years complete one year of CPD activities and if greater than three years submit a professional development plan to the Board. The Medical Council of New Zealand requires doctors returning after a three year break submit a detailed induction plan on their application to return. Evidence of competency after a 3 years break is required to be submitted to the Conseil national de l'Ordre des médecins, in France (http://www.gmc-uk.org/Skills_fade_literature_review_final_Report.pdf_60956354.pdf).

The 2010 Physician Licensure Survey found that 51% of medical boards have a policy on physician re-entry; 2.8 years is the average length of time out of practice and that 55% of medical boards without a physician re-entry policy are either currently developing or planning to develop a re-entry policy (http://www.ama-assn.org/ama/pub/education-careers/finding-position/physician-reentry.page).

According to the Federation of State Medical Boards (FSMB), "It is important for the physician to understand that medical licensure renewal is based on continuing professional development even if taking a leave from clinical practice and the burden of proof is on the physician to show that he or she has met the appropriate requirements for licensure" (http://physician-reentry.org/wp-content/uploads/TipsforHandlingInquiriesFINAL.pdf). They adopted a Reentry to Practice policy at its annual business meeting on 28 April 2012. Since that period the AAP (with the AAMC and FSMB) have

created a resource for pediatricians navigating reentry, and recently have launched a resource tool for employers faced with this process. Family Medicine does not yet have a specialty specific tool.

The Post Licensure Assessment System (PLAS) is a joint project in the US between the National Board of Medical Examiners (NBME) and FSMB was developed to assist medical licensing authorities in assessing physicians who have already been licensed (http://www.nbme.org/clinicians/index.html). These exams are a combination of computer based clinical simulation and multiple choice questions (both general and specialty based). The Special Purpose Exam (SPEX) is tailored to physicians in some form of reentry process. Currently they have collaborated with outside organizations to create the standardized testing for reentry programs. There are many ways a re-entry process can play out in the academic arena. It can be via a universities, medical societies, state medical boards or private organizations. The curricular framework may also be varied.

The cost of reentry programs is not inconsequential to either learner or program. Legislative and legal considerations include potential liability for the programs and faculty in future malpractice cases as well as lawsuits from excluded potential participants in the program (http://physician-reentry.org/wp-content/uploads/reentry_issuebrief7_A-E.88133644.pdf). To that end the FSMB backed the Primary Care Physician Reentry Act along with the AMA, the AAP, and the AAFP which when passed, allows organizations to apply for grant funding, and design a program for re-entry training while the malpractice insurance is be covered through the Federal Tort Claims Act (this, however, has yet to pass) (http://www.medpagetoday.com/PublicHealthPolicy/GeneralProfessionalIssues/47911). As of October 2014 it Reentry Act had been referred to the Committee on Energy and Commerce (http://www.doctorslounge.com/index.php/news/pb/50209). In Canada, the Ministry of Health and Long-Term Care (MOHLTC) offers funding each year for physicians currently practicing in Canada to re-enter postgraduate medical training with a return of service commitment to practice in an underserved area for two years in the specialty in which they are trained (http://www.health.gov.on.ca/en/pro/programs/hhrsd/physicians/licensing.aspx). Here in the US, creating a national reentry program will require looking to numerous funding sources (https://download.ama-assn.org/resources/doc/med-ed-products/x-pub/physician-reentry-regulations.pdf). In the United Kingdom, some organizations such as The Committee of General Practice Education Directors (COGPED) offer retraining programs for primary care physicians who have been out of practice for an extensive period of time (http://www.who.int/mediacentre/news/releases/2015/partnership-primary-health-care/en/).

Why should physicians care about the process? Socio-political issues with regards to who determines the needs assessment and what the guidelines are based, should really be the purview of the medical specialty to which the physician belongs. Assessment and evaluation should be within the guidelines of already established standards via the various accrediting agencies within countries along with assessments at the start of the program, upon completion and again a period of time after resuming clinical practice (https://download.ama-assn.org/resources/doc/med-ed-products/x-pub/physician-reentry-regulations.pdf).

Completion of a reentry program occurs when a physician has returned to their practice setting and has demonstrated their competence in relation to their specific specialty (http://physician-reentry.org/wp-content/uploads/reentry_issuebrief3_final.88130428.pdf). Physicians can be peers and mentors in navigating this process understanding that there is accountability. Recommendations were made that a certificate of completion be issued with details as to which specific competencies were addressed; using a baseline curricular framework (for standardization) with flexible individualized education plans (IEP) based on the physicians educational gaps. The program itself needs to hold itself to a standard that fulfills the learners' rights: full disclosure, appropriate resources, timely learner assessment and feedback, competent faculty and program self evaluations and improvements (http://physician-reentry.org/wp-content/uploads/reentry_issuebrief5_final.88133604.pdf).

A good reentry program needs to be accessible by geography, time and cost; comprehensive, flexible, innovative, accountable, financially sound, and have collaborations with other resources and

programs (http://www.ama-assn.org/ama/pub/education-careers/finding-position/physician-reentry.page). Our network of family physicians can span the geography, our current educational resources online and in person fulfill the other criteria. The key is to collaborate. The ability to offer part-time training, regional locations and return-of-service financial assistance are incentives listed by the physicians surveyed in British Columbia (Jamieson et al., 2010). Sectish et al. (2015) in their pediatric blueprint for action recommended creating a "model of funding for education and training that follows the trainee, not the institution" referencing the US system of GME financing. If allocated funds did follow a trainee, there would be the potential to have cost savings that could be utilized for CPD later in their careers.

Physicians need to know the following:

1. If leaving practice, do your homework and research your location's medical board require- ments, there is a cost to reentry and lifelong learning will be required (http://physician-reentry. org/wp-content/uploads/6ReasonsTalkwithBoardFINAL.pdf).
2. If contemplating reentry, do your homework and research your needs for your future practice, determine your IEP and schedule capabilities, decide which program meets your needs and understand what constitutes completion of the program.

   a. What location do you intend to work in (ambulatory, inpatient, nursing home, etc.).
   b. What are the board certification requirements and licensing requirements in your specialty.
   c. Attend (online or live) didactice sessions to get reacquainted with the new clinical guidelines as well as the practice management requirements for your intended field.
   d. Based on the information gathered above, determine what your current knowledge gaps are and create your IEP so that you can focus future sessions on addressing these deficiencies.
   e. If needed, register and prepare to sit for any certification or licensing examinations.
   f. Research live sessions that provide for simulation as well as team based experiences with actual patients. There will need to be an opportunity to become a "resident" again whereby a currently certified physician precepts your work and can attest to your clinical skills.
   g. Try to search for an independent assessment process via a local residency program or medical school or by way of the specialty society in your area.
   h. Document extensively and keep a log of all the activities you have done during this period and be prepared to submit this to your new place of employment.

The major stakeholders in this process are the physicians, regulatory agencies, clinical practice institutions, reentry programs, medical associations and societies and the public (https://download.ama-assn.org/resources/doc/med-ed-products/x-pub/physician-reentry-regulations.pdf). Current AAFP policy (2010) regarding reentry is that it should: (a) be transparent for physicians and the public, (b) integrate into current licensure and maintenance of certification procedures, and (c) focus on helping physicians to deliver effective, efficient and high-quality patient care. Our role as an academic community is to remain vigilant and continue to educate our members with regards to resources and strategies that are available (https://download.ama-assn.org/resources/doc/med-ed-products/x-pub/physician-reentry-regulations.pdf). Our potential goal may well be to ensure each specialty becomes the main resource for reentry in the future.

An ideal program would include the utilization of online didactic sessions over several weeks supplemented by live sessions that incorporate team based learning and simulation. Goldberg, Samuelson, Levine, and DeMaria (2015) showed the use of simulation as a tool for physician reentry citing 73% of the participants who have presented to their center for retraining via simulation successfully reentered and were in active in practice for at least 1 year after participation. Jaquet et al. (2015) reported on the creation of a series of interactive modules to prepare learners to safely and effectively participate in global health rotations and projects, a model that can be extrapolated to reentry courses.

Balmer, Marton, Gillespie, Schutze, and Gill (2015) found that residents who entered a reentry program after a prolonged absence suffered from various emotional responses. The program would have to take into consideration the emotional toll of a reentry program and likely institute a form of Balint sessions to help support the physicians through this process. Residency programs might consider creating safety nets to help cultivate support for residents when they reenter training.

The Drexel physician reentry program published their results over a 6 year period showing 6 out of 9 obstetrics and gynecology physicians successfully returning to practice after their program (Varjavand, Pereira, & Delvadia, 2015). This structured yet individualized program provides reeducation and assessment for physicians who have left clinical medicine for any reason and are hoping to return.

Future recommendations would be to create a specialty driven taskforce that reviews and combines best practices for reentry programs taking into consideration a standard guideline as to the time away from practice which would constitute the necessity to engage in the program. Creating a bank of information for various physicians regardless of how they travel internationally on the current requirements for reentry is important. We would then pool our resources for cognitive rehabilitation which can be done via online modules and live sessions at regional conferences supported by various medical societies. The next step would be to ensure a rigorous evaluation process that could be accredited by medical licensing bodies.

Hughes et al. (2015) outlined a detailed plan to build the primary care workforce needed to accommodate our ever evolving health care system. One of their recommendations focused on reentry—“developing CPD opportunities that deliver retraining for practicing physicians to learn new skills and understand new models of care.”

If we could assist each other on an international level, we would be far ahead of the game in terms of a specialty society working to impact primary care shortage globally.

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The authors declare no competing interest.

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