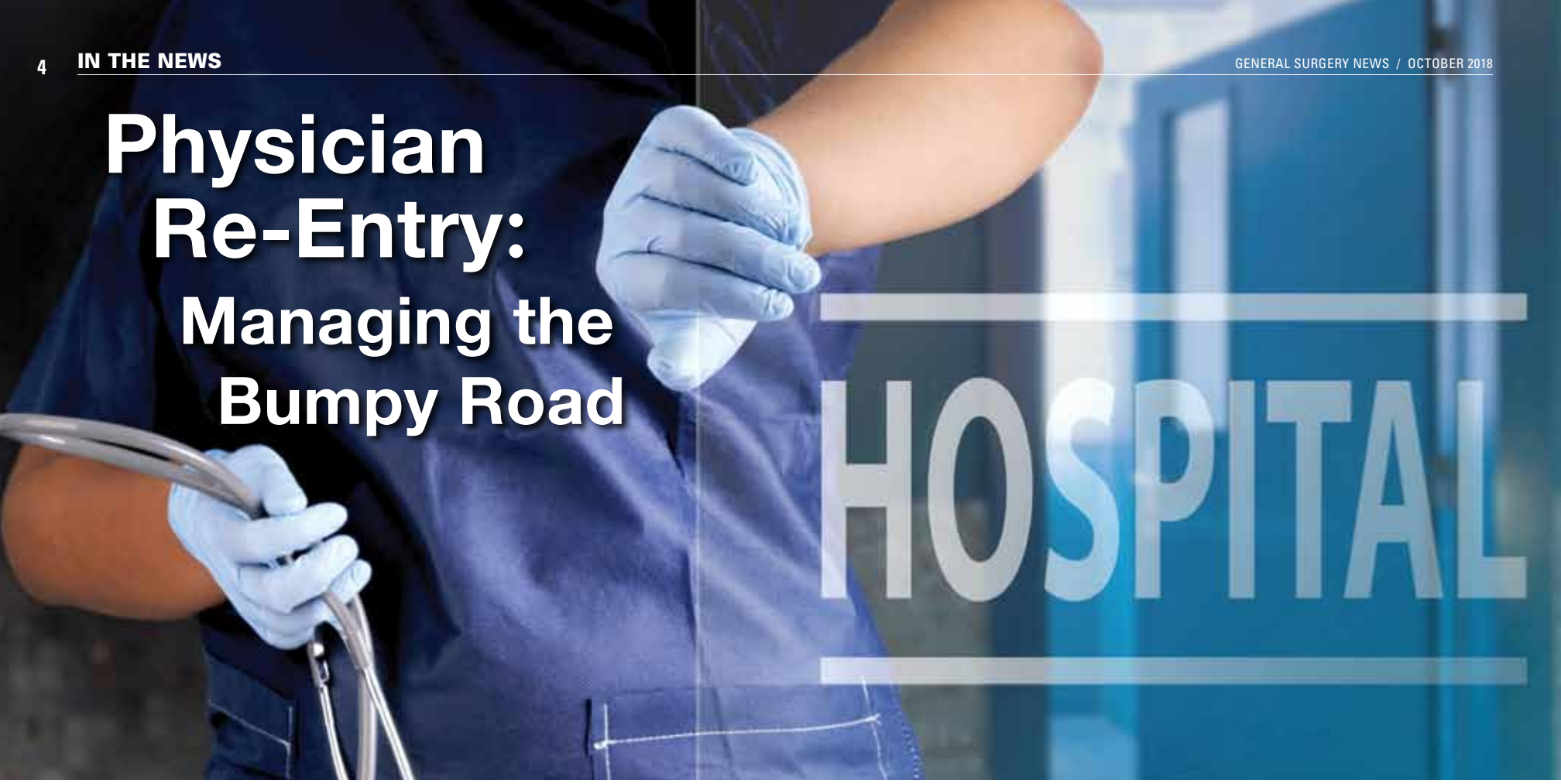
Physician Re-Entry: Managing the Bumpy Road



By VICTORIA STERN

In 2012, Marcellus Pearce, MD, needed a break from his busy practice. Over four years of 15-hour days plus several nights a week on call had taken its toll on the OB-GYN specialist.

"I was fried and made a decision to get some balance in my life before burnout set in," said Dr. Pearce, who had built a practice at a community health center in Texas that served high-risk patients. "My plan was to take off a few months to travel, but that quickly turned into almost two years."

By early 2014, Dr. Pearce was eager to re-enter clinical practice. However, the return to medicine was not as seamless as he had hoped. "When I was ready to go back to work, it was harder than if I had just come out of residency," he said.

Dr. Pearce had maintained his medical license, but to regain hospital privileges insurance companies wanted to know about his operative experiences over the past two years. He had none.

"It was a steel wall I could not get around," Dr. Pearce said. "I needed recent surgical time, and there was no readily available mechanism in place to pick me back up into the system."

It took Dr. Pearce three more years before he was practicing medicine again.

Dr. Pearce is not alone in his struggle to return to clinical practice after time away. The pathway for physicians who have left medicine voluntarily or for nondisciplinary reasons is often difficult, said Leo Gordon, MD, a general surgeon in Los Angeles and an editorial board member of *General Surgery News*. "Most [physicians] do not realize the dramatic change in the credentialing process that has occurred during their absence."

Physicians leave medicine for a variety of reasons. Available data show that re-entry affects as many men as women, and the top reason for leaving practice is personal or family health issues, although new career opportunities, child-rearing, retirement and professional dissatisfaction are also high on the list (*Clin Colon Rectal Surg* 2012;25[3]:171-176; *Hum Resour Health* 2011;9:7).

Doctors seeking re-entry may face a range of challenges. Some physicians need state medical boards to reissue their license, hospitals to award privileges, and malpractice insurers to grant coverage. Most will need to show credentialing committees that they are up to speed on the latest treatments, technologies and techniques, and that their skills in the operating room (OR) and with patients remain strong.

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>
> —Jo Buyske, MD

But ticking these boxes can be tricky. Some medical societies, such as the American Medical Association (AMA), American Academy of Pediatrics and American Board of Surgery (ABS), offer re-entry guidelines for physicians who have been out of practice for an extended period, but there are no national standards in place to help doctors return. In fact, almost half of medical boards do not have policies on physician re-entry, and for those that do, requirements vary. Some medical boards ask for proof of continued medical education or clinical competency, while others may request doctors to attend one of the few established physician re-entry programs in the United States.

"It is very difficult to make re-entry requirements completely uniform given that different specialties require different technical skills and training, and given the variability in what states consider active practice," said Elizabeth Grace, MD, the medical director of the Center for Personalized Education for Professionals, or CPEP. "For instance, because of the technical skills required of surgeons, privileging bodies may hold them to a different level of scrutiny or use different criteria."

Further complicating the landscape is the fact that it's unclear how many inactive physicians are seeking re-entry. One frequently cited statistic, extrapolated from a 2007 study of Arizona physicians, estimates that approximately 10,000 physicians could be returning from inactive status each year (*J Contin Educ Health Prof* 2011;31[1]:49-55). A 2008 survey of 1,162 inactive physicians reported that almost 20% of respondents had returned to practice after time away, and less than one-fourth had "firm plans" to re-enter (*Hum Resour Health* 2011;9:7). But these decade-old estimates may not reflect current realities.

"There are no good statistics on how many physicians want to come back," said Nielufar Varjavand, MD, the program director of the Drexel Medicine Physician Refresher/Re-Entry Course, in Philadelphia. "It just doesn't exist."

A Re-Entry Plan for Surgeons?

Data on surgeon re-entry are limited. Over the past seven years, Jo Buyske, MD, the executive director of the ABS, has shaped re-entry pathways for 22 surgeons using the ABS guidelines she developed. She has received many more calls from surgeons eager to learn about their re-entry options.

"Surgeons have invested a huge amount of time and energy in their training, and to slam the door behind them forever because of an illness or family obligations is crazy," said Dr. Buyske, who had her own parallel re-entry experience while she was developing the ABS guidelines. "That is why physicians who want to come back should have a pathway readily available to them."

When Dr. Buyske began working at the ABS in 2008, she left her role as the chief of surgery and director of minimally invasive surgery at Penn Presbyterian Medical Center, in Philadelphia. But Dr. Buyske missed surgery and after two years out of the OR, she began exploring her options to return. The head of trauma at Penn Presbyterian suggested she join the hospital's acute care services team.

"At that time, the field of acute care surgery was just emerging," Dr. Buyske said. "This team-based model worked very well for me, allowing me to operate several times a month while balancing my work at ABS."

continued on page 6

Physician Re-entry

continued from page 4

But before jumping back in, Dr. Buyske wanted to brush up on her skills. "Even after two years, there's a lot to catch up on," said Dr. Buyske, who took charge of her re-entry pathway by doing supervised cases, taking courses and practicing in the simulation lab. "I had lost a lot of automaticity in my time away, but after several days in the OR, I was back in the groove."

Dr. Buyske's experience returning to practice helped inform the ABS re-entry guidelines, which recommend that surgeons find a local physician champion who can assess six key competencies—medical knowledge, patient care, professionalism, communication, practice-based learning and systems-based practice—and develop a proctoring plan, which provides decreasing degrees of supervision in the OR until returning surgeons can operate independently.

But Dr. Buyske stressed that the ABS guidelines are exactly that—guidelines. "Each case is different and re-entry plans need to be individualized to reflect those nuances," she said.

An Uncertain Road Back

The strong institutional support that Dr. Buyske received combined with an understanding of the training she would need to re-enter provided a fairly smooth return to surgery, but many physicians may not know where to start and how to fill the gaps left by their absence from practice.

To address potential gaps and appease credentialing committees, these physicians may need to consider a formal physician re-entry program. But, in the United States, fewer than a dozen such programs exist. The programs are also demanding of time and resources, typically costing physicians between $5,000 and $10,000 a month and some requiring doctors to relocate.

"[Re-entry programs] are a really big commitment," said Robert Steele, MD, the director of the KSTAR physician programs at Texas A&M Health Science Center, in College Station, who receives calls almost every day from doctors inquiring about the program.

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—Kenneth Fortier, MD

KSTAR offers mini-residency opportunities for physicians to verify or improve their skills and medical knowledge. The mini-residency, which typically lasts three months and requires doctors to relocate to Galveston, starts with an intensive two-day assessment. The assessment allows KSTAR to evaluate gaps and provide a plan tailored to each doctor's needs, which can include time in the OR, simulated or hands-on patient care, and electronic health record training.

"Physicians at KSTAR are essentially coming back into the residency setting and getting intensive training that addresses all core competencies," Dr. Steele said. "After completing the program, physicians who have let their medical license lapse can petition their state board to reactivate it."

However, Dr. Steele explained it's often not possible to accommodate all the people who want to be in the residency program because of volume and crowding concerns. "It costs quite a bit to train returning doctors, and we have to make sure we're not taking resources away from current residents," said Dr. Steele, noting that the program currently trains eight to 10 physicians a year.

Dr. Pearce contacted KSTAR in early 2016, hoping to get one of the program's coveted spots, but he had to wait almost a year for an opening.

"It was like one body blow after another trying to get back into practice, and I felt blessed to have that spot at KSTAR come up when it did," said Dr. Pearce, who moved to Galveston in April 2017 to start the program. "I was attached to a team of residents and would do two- to three-week rotations in different areas. Initially, I had to accept the fact that things didn't happen as fast physically for me after not performing surgeries for four years, but it didn't take long to get back in the swing of things."

For Dr. Pearce, the costs of the mini-residency program came to about $23,000, plus another $5,000 to move to Galveston for three months. "I don't know if there's a way around the expense," he said.

Dr. Pearce, however, found that an advantage to the on-site residency was the ability to pick up extra cases. "I lived just a mile away from labor and delivery, so I was able to jump in when needed and did enough cases to get my malpractice insurance back."

Other programs—one at Drexel University in Philadelphia, and one at Oregon Health & Science University in Portland—also provide on-site mini-residency or structured preceptorship opportunities. Dr. Gordon developed a re-entry program at Cedars-Sinai Medical Center in Los Angeles, although it is currently on hold.

Re-entry at Home

Kenneth Fortier, MD, never thought he'd be healthy enough to return to medicine. He had left his busy OB-GYN practice in 2005, after two decades in practice, because of poor health.

"My internist told me I was going to be dead within a year because my diabetes and related metabolic conditions were out of control," he said.

But after undergoing gastric bypass surgery in 2011, his health began to improve and he realized it might be possible to come back part-time. (The 2008 survey of inactive physicians found that the main factor driving re-entry was the availability of part-time work or flexible scheduling.)

"I had really missed my patients and my practice," Dr. Fortier said.

After attending an inspiring lecture, Dr. Fortier approached the director of a program that cares for pregnant women with drug use disorders and was offered the opportunity to work in the OB-GYN residents' clinic at the University of North Carolina at Chapel Hill. But more than a decade out of medicine meant he needed some retraining to satisfy credentialing committees, and he was directed to CPEP for a formal re-entry plan. CPEP provides a practice-based pathway for physicians who exited medicine in good standing to resume practice. Aside from an assessment, which occurs at one of the CPEP's locations in Denver or Raleigh, N.C., physicians can complete their individualized re-entry plans in their home community, while under the guidance of an approved preceptor.

"Our hope is that the individual will identify a prospective position and provide clinical care under supervision in the place where they will ultimately practice," said Dr. Grace, the medical director of CPEP. "We will tailor the re-entry evaluation and plan for basically any specialty and supervise progress remotely, typically over three to nine months until the physician can work independently."

GSN Welcomes New Editorial Advisory Board Member, Yosef Nasseri, MD

After obtaining his bachelor's degree from the University of California, Los Angeles, Yosef Nasseri, MD, attended medical school at the Albert Einstein College of Medicine, in New York City. He then completed a seven-year general residency, with a year dedicated to research at the Cedars-Sinai Medical Center, in Los Angeles.

After his residency, Dr. Nasseri completed a fellowship in colorectal surgery at the Cleveland Clinic Florida, in Weston. Dr. Nasseri is now double board-certified in general and colorectal surgery, specializing in robotic and minimally invasive techniques for the treatment of colorectal diseases, including inflammatory bowel disease, as well as malignant and benign colorectal diseases. He is a founding member of the Surgery Group of Los Angeles, a large multispecialty surgery group, and one of Southern California's most prolific robotic colorectal surgeons.

In addition to a high clinical volume, Dr. Nasseri is very active in clinical research and academia. He regularly collaborates with surgeons and physicians from diverse specialties, conducting multiple prospective and retrospective research projects with the support of a dedicated research staff and the backing of the Surgery Group's research foundation. Dr. Nasseri's research is primarily outcomes based, with a concentration in both benign and malignant colorectal diseases. By focusing on patient outcomes, he can introduce and test new treatment modalities and algorithms. Through this work, he has published several book chapters, journal articles and presented at various conferences. His role also extends to regularly editing journal articles.

Dr. Nasseri is a committee member and contributor of the American Society of Colon and Rectal Surgeons, Consortium for Optimizing the Treatment of Rectal Cancer, and American College of Surgeons, among others. He also served on various committees at Cedars-Sinai over a span of several years. These committees include the MD–RN collaborative, robotic steering committee and cancer committee. He also completed a leadership program at Cedars-Sinai.

Although finding a preceptor can be a challenge for some applicants, Dr. Fortier felt fortunate to find one almost immediately. "I was in the right place at the right time," Dr. Fortier said. "My preceptor also happened to be an examiner for CPEP. The program asks for a lot from a preceptor, so I felt fortunate to have found someone so generous with her time."

For Dr. Fortier, the entire process—from scheduling an assessment to getting the final report—took about 10 months. He recently received the green light to return to practice from CPEP.

"Re-entry is a pain in the neck but I'm much better for having done it," Dr. Fortier said. "The program reawakened my love of caring for patients and I feel more secure and confident as a physician."

Future Re-entry Needs

Supporting physician re-entry has become especially relevant in recent years, given the predicted physician shortage. A 2018 analysis from the Association of American Medical Colleges estimates that the United States could experience a shortage of 40,000 to 120,000 physicians by 2030, including 20,700 to 30,500 physicians in surgical specialties.

But even after completing a re-entry program, physicians are not assured the effort will pay off in hospital privileges or a job.

Dr. Pearce found a staff OB-GYN position at the People's Community Clinic in Austin, within six months of completing the KSTAR program. "I'm very happy to be back," he said. "I can't say enough nice things about the people at KSTAR. The program did exactly what it needed to do: It got me back seeing patients."

In contrast, Dr. Fortier has not yet found employment. "I had an opportunity fall through, which was heartbreaking, but I hope there are opportunities to work in practices near me," he said.

Creating a more standardized national pathway for physicians to return to practice might help streamline the process, but efforts to do so have not gotten off the ground. For instance, in September 2014 and again in December 2015, Sen. John Sarbanes (D-Md.) proposed the Primary Care Physician Reentry Act to facilitate re-entry into primary care, but the bill has yet to receive a hearing.

"Having 'MD' after our name is a hard-earned privilege," said Dr. Gordon. "Organized medicine should do everything it can to facilitate re-entry for those who obtained that privilege and who, for legitimate reasons, had to or chose to leave the profession for an extended period of time."

It takes so much to create a physician, Dr. Gordon said. "We constructed the path in; let's work on the path back."

What Doctors Should Do Before and During a Hiatus

Do not give up your medical license. "Try to keep it renewed and active," Dr. Steele said.

Maintain board certification and current continuing medical education requirements. "If a physician must leave for an extended period of time, map out a re-entry pathway *beforehand*," Dr. Gordon said. Provide detailed explanations for why you left medicine and any efforts to return before applying for jobs.

Keep your head in the game and stay informed about your field. "After several years out of practice, medicine and technology can change so much it can be disorienting," Dr. Steele said. "Stay up-to-date."

Don't exit medicine entirely. "My biggest advice is don't leave, at least not completely," Dr. Varjavand said. If possible, plan how to keep clinically active and educated.

When looking to return, reach out to colleagues. "You cannot do the re-entry process with emails and voicemails; personal effort with a face attached to it is key," Dr. Gordon said. "Contact a group of busy clinicians to ask about opportunities to shadow them or discuss cases. Set up a face-to-face meeting with the chief of a hospital and the head of the credentials committee."