Education to Return Nonpracticing Physicians to Clinical Activity: A Case Study in Physician Reentry

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Introduction: Physician shortages in the United States are estimated to reach as high as 85,000 by 2020. One strategy for addressing the shortage is to encourage physicians who left clinical practice to return to work, but few programs exist to prepare physicians to reenter practice. The Divisions of Continuing Medical Education and Graduate Medical Education (GME), Oregon Health & Science University, collaborated with clinical departments to establish a physician reentry program.

Methods: A case-study of education designed to return nonpracticing physicians to clinical activity was undertaken.

Results: Fourteen candidates were accepted into the program. Accepted candidates were appointed special fellows at the university and provided with restricted institutional license and liability coverage. Based on retraining assessment and planned scope of practice, applicants and program directors designed individualized curricula. As trainees demonstrated clinical proficiency, their level of independence increased in a condensed version of the residency training model. Of the 14 accepted candidates, 13 successfully completed the program and are actively engaged in clinical practice. One trainee did not successfully complete the program.

Discussion: This reentry program reintroduced clinically inactive physicians into supervised direct patient care. Use of the GME model allowed acceptance of special fellows and provided institutional malpractice coverage for them.

Key Words: education, medical, continuing, reentry, clinical practice, physician, retraining, case study

Background

National reports indicate the United States will face a shortage of 55,000–85,000 physicians by the year 2020.\textsuperscript{1,2} Concomitantly, there are increasing numbers of physicians working reduced hours or leaving clinical practice for periods of time.\textsuperscript{3} Female physicians have been more likely to adjust work hours or interrupt practice due to family responsibilities;\textsuperscript{4,5} however, recent data show increasing numbers of male physicians altering their careers for similar reasons.\textsuperscript{6} Although the most common reason for career interruption is family responsibilities, primarily the care of children or ill family members,\textsuperscript{4-6} personal illness,\textsuperscript{7} career dissatisfaction,\textsuperscript{8,9} and alternative careers\textsuperscript{7,10} are also frequent reasons for periods of clinical inactivity. One potential strategy for addressing the physician shortage is to encourage qualified, nonpracticing physicians to return to the work force.

Nonpracticing physicians face many hurdles to reentering clinical work. Anxiety and lack of confidence about clinical skills, concerns associated with reviewing and updating medical knowledge, and a dearth of information and support for the reentering physician are imposing barriers.\textsuperscript{7,11,12} Increasingly, regulations set by states for regaining a medical license and by health care institutions for credentialing are additional obstacles to physicians returning to practice. Most states recommend, and 6 require, physicians who take a leave of absence for more than 24 months to participate in a physician reentry program.\textsuperscript{11,13} Doctors who take a leave...
of absence from practice are often not aware such requirements exist.

Finally, the need for reentry resources outstrips the resources available. There are a limited number of reentry programs in the United States that provide detailed evaluation of physicians’ medical knowledge, neuropsychological status, and skills maintenance. However, until recently, virtually no program offered a supervised, hands-on clinical experience where physicians refresh their skills without repeating a residency program. Thus, it is not surprising physicians find the barriers to returning to practice difficult to overcome.

In response to multiple inquiries from the Oregon Medical Board and physicians seeking to reenter practice, the Divisions of Continuing Medical Education and Graduate Medical Education (CME and GME) at Oregon Health & Science University (OHSU) collaborated with faculty to establish a physician reentry program in March of 2006. The objective of the program is to assist physicians in good standing to return to clinical practice after a period of absence by providing individualized learning experiences focused on identified goals and based on supervised clinical activity. The program is not a substitute for a residency program and is not designed for physicians who wish to enter a new medical discipline. The reentry program has been able to return physicians to the work force in months, an efficient and relatively inexpensive means to increasing physician manpower and protecting societal investment in physician training.

Objective

This case report describes an innovative educational intervention to return nonpracticing physicians to clinical activity implemented by collaborations among the divisions of CME, GME, and clinical departments. It reviews the reentry trainees’ outcomes from March 2006 to January 2010.

Methods

Participants and Application Process

Participants are referred to OHSU by the medical board or are self-referred after learning about the program through publications or the OHSU CME Web site. Admission to the program is selective and overseen by an admissions committee. The committee includes representatives from OHSU and other training sites in Portland. Candidates submit an application including education and employment history, letters of reference, documentation of medical school graduation, completion of an Accreditation Council for Graduate Medical Education (ACGME)-accredited residency, medical specialty board certification, and licensure. The application has been amended to include questions regarding reasons for leaving clinical practice, types and amount of CME or other methods used to stay current, reasons for re-entering practice, goals for the reentry program, and desired scope of future practice.

Each candidate’s application is reviewed by the admissions committee. We do not employ a structured point system in evaluation of applications as it is not clear how different components of the application should be valued. Consideration is given to the number of years the physician has been out of practice, the number of years of practice prior to the period of inactivity, and the amount of CME, medical volunteer work, or other engagement in medicine during clinical inactivity. We have not set firm limits on these factors, for example, by denying admission to candidates with more than an arbitrary number of years out of practice. We do value a candidate’s attempts to keep his or her knowledge up to date by CME or other means and evidence of continued engagement in medicine. Candidates who have had any form of disciplinary action or have left practice because of remedial needs are not considered. Although there is evidence pointing to the success of remedial professional development programs, this was not the goal of the reentry program. Preference is given to physicians from Oregon.

If the admissions committee recommends acceptance, the application is reviewed by the appropriate program director. The program director for reentry training is typically, but not always, the residency program director. Both the program director and the dean of CME interview the candidate. The program director makes the final decision on acceptance of a candidate based on his/her determination of the needed focus and duration of reentry training and the availability of faculty and educational opportunities within the department. Reentry training cannot adversely impact the learning environment for the School of Medicine’s primary learners (medical students, residents, and fellows).

Accepted candidates are appointed special fellows at the university. They are provided the same restricted institutional license and liability coverage as all other OHSU residents/fellows. Reentry trainees must comply with the same institutional requirements and coursework as residents and fellows, including application for a limited license to allow for institutional practice. Special fellows are not part of the residency programs’ ACGME-approved complement of residents and fellows, and their presence in individual departments must be approved by the institutional GME committee.

Assessment and Training

Once an applicant is accepted, the program director determines the appropriate initial assessment tools. Examples of assessment methods have included standardized examinations, simulated patient evaluations or procedures, and observed clinical encounters. Standardized examinations have included resident in-training exams and specialty board certification exams. In fact, we encourage trainees to participate in specialty board recertification as a method of knowledge...
assessment and an adjunct to the reentry program. Both ob/gyn and general surgery programs have assessed trainees in their virtual procedure laboratories. All trainees are directly observed in supervised clinical encounters. Some program directors have required an initial 2–3-week period of observation by experienced clinical faculty before agreeing to additional training. There is not a standard protocol for initial assessment, and program directors have relied on the same tools they have available for assessing their resident learners.

Based on the pretraining assessment and planned scope of practice, the trainee and the program director design an individualized curriculum that includes goals and objectives, description of planned clinical experience and responsibilities, duration of training, and expected outcomes. The curriculum provides a guideline but may be adjusted as training progresses to address learning gaps as they are discovered. For example, a reentering internist may discover a greater knowledge deficit than expected in the area of diabetes management and additional clinical experiences in our chronic illness management diabetes clinic may be added to the curriculum. A standard contract outlining the projected duration of training and estimated cost is signed by the applicant, program director, and the executive director of the hospital and clinics. The contract explicitly states initiation of the training program does not guarantee successful completion.

Reentry trainees are an active part of the patient care team; they do not merely observe or shadow the clinical team. Trainees complete electronic medical record training and coursework on respect at the university and HIPAA regulations. Trainees write orders and prescriptions, interpret test results, enter documentation in the electronic medical record, and perform diagnostic and surgical procedures. They interview and examine patients, develop diagnostic and therapeutic plans, and interact with all members of the patient care team. Initially trainees work under the close supervision of clinical faculty, and patient care skills are directly observed. As trainees demonstrate clinical and technical proficiency, their level of independence increases in a condensed version of the residency training model. Feedback is provided regularly, and the trainee meets with the Assistant Dean of CME monthly for debriefing.

The criteria used to evaluate reentry trainees are similar to those used to evaluate residents in ACGME-accredited residency programs. The structure of evaluation is determined by the program director and has ranged from Likert scale evaluation of each ACGME competency to a global written assessment by the faculty mentor. A trainee is expected to continue in the training program until he or she meets the level of competence of a graduating resident or until it is determined that he or she is highly unlikely to reach that level of competence. If training is completed successfully, a letter is provided to the graduate describing the clinical experiences and duration of training and includes a summary of faculty evaluations. No certification of competence is provided.

Costs and Financing

The reentry program is self-supporting; there is no external funding. The cost of the program is borne by the trainee, although some future employers have shared the expense. At the time the candidate is accepted and curriculum planning begins, a $5000 nonrefundable deposit is required to cover administrative costs and initial curriculum development. Half of this amount is paid to the CME office for administration and overhead and the other half is applied to the total tuition.

Tuition fees have ranged from $1600 to $10000 per 4-week period and were based on the departments’ estimates of cost, lost productivity of faculty engaged in mentoring the trainee, and degree of risk; that is, trainees requiring surgical or obstetrical training paid higher tuitions. The CME office has not set standard guidelines, but has worked with each department to develop a structure for charges. Some departments charge a flat monthly rate, and others charge a lower base rate plus a variable component dependent on the number of clinic sessions attended.

Demographic information is collected on all applicants. Exit interviews are conducted with all trainees and program directors at the conclusion of training. Employment and clinical activity of program graduates are tracked, and a long-term follow-up protocol is being established.

Results

In the past 48 months, 38 applications have been reviewed, and 14 candidates have been accepted into the program. Of the 14 accepted candidates, 13 have completed the program and are engaged in clinical practice. One trainee did not complete the program. In that case, the program director and trainee mutually agreed the trainee would be unable to practice independently and his training was discontinued. Nineteen applications were rejected and 6 are pending review.

Demographics of Accepted Applicants

We were contacted by physicians from almost every major specialty (TABLE 1). The average age of the 14 physicians who participated in the program was 56 (range 33–72 yr). Fifty percent were female and the average length of clinical inactivity was 7 years (range 1–17 yr). Ten of the 14 had at least 1 active medical license, and 10 had current or lifelong board certification in their specialty (TABLE 2).

Reasons a Reentry Program Was Needed

There were multiple reasons physicians contacted us regarding their need for a reentry program (TABLE 1). The most common were needs for a defined clinical experience to allow them to expand scope of practice within their disciplines and absence from clinical practice due to personal illness. The need to expand scope of practice was frequently due to the demands of a new clinical position. In addition to
personal illness, physicians had left clinical practice to take care of family responsibilities, to pursue nonclinical career opportunities, or to retire. A smaller number had allowed their medical licenses to lapse or were ordered to undergo remedial training. Of the accepted candidates, 5 wished to expand their scope of practice, 3 had taken time off because of personal illness and 2 because of family responsibilities, 3 had retired and wished to return to practice, and 1 had pursued a nonclinical career opportunity.

**Reasons Candidates Were Not Accepted**

The admissions process is selective and candidates were not accepted into the reentry program for several reasons (TABLE 3). Candidates who had any form of disciplinary action or left practice because of remedial needs were not considered. Physicians who had substance-abuse issues and those who had problems with communication, interpersonal relationships, and professionalism were also rejected. We were contacted by several physicians who had not completed an ACGME-approved residency program, and these physicians were not considered for admission.

**Feedback From Trainees and Program Directors**

Generally, trainees have found their experience valuable and feel prepared to take care of patients upon completion of the program. Every trainee identified the hands-on aspect

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**TABLE 1. Characteristics of Applicants Considered for Admission to the OHSU Physician Reentry Program**

<table>
<thead>
<tr>
<th>Reason Reentry Program Soughta</th>
<th>Applicants (No.)</th>
<th>Specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Desired expanded scope of practice (in original discipline)</td>
<td>9</td>
<td>Internal medicine 11</td>
</tr>
<tr>
<td>Personal illness</td>
<td>9</td>
<td>OB/GYN 9</td>
</tr>
<tr>
<td>Family responsibilities</td>
<td>7</td>
<td>Family medicine 6</td>
</tr>
<tr>
<td>Premature retirement</td>
<td>5</td>
<td>Pediatrics 4</td>
</tr>
<tr>
<td>Lapsed license</td>
<td>2</td>
<td>General surgery 3</td>
</tr>
<tr>
<td>Pursued nonclinical career opportunity</td>
<td>2</td>
<td>Psychiatry 1</td>
</tr>
<tr>
<td>Remediation mandated</td>
<td>3</td>
<td>Other (Urology) 3</td>
</tr>
<tr>
<td>Other (had not completed residency)</td>
<td>3</td>
<td>Other (Gastroenterology) 1</td>
</tr>
</tbody>
</table>

*More than 1 reason for seeking reentry could be listed.*

**TABLE 2. Demographics of OHSU Physician Reentry Program Participants**

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Gender (M/F)</th>
<th>Age (yr)</th>
<th>Active License (Y/N)</th>
<th>Board Certified (Y/N)</th>
<th>Clinical Inactivity (yr)</th>
<th>Duration of Training (wk)</th>
<th>Clinically Active After REP (Y/N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family medicine</td>
<td>F</td>
<td>56</td>
<td>Y</td>
<td>Y</td>
<td>17</td>
<td>13</td>
<td>Y</td>
</tr>
<tr>
<td>Family medicine</td>
<td>M</td>
<td>61</td>
<td>N</td>
<td>N</td>
<td>5</td>
<td>17</td>
<td>N*a</td>
</tr>
<tr>
<td>General surgery</td>
<td>M</td>
<td>57</td>
<td>N</td>
<td>N</td>
<td>9</td>
<td>4</td>
<td>Y</td>
</tr>
<tr>
<td>Internal medicine</td>
<td>M</td>
<td>54</td>
<td>N</td>
<td>Y</td>
<td>8</td>
<td>5</td>
<td>Y</td>
</tr>
<tr>
<td>Internal medicine</td>
<td>F</td>
<td>54</td>
<td>Y</td>
<td>Y</td>
<td>11</td>
<td>10</td>
<td>Y</td>
</tr>
<tr>
<td>Internal medicine</td>
<td>F</td>
<td>55</td>
<td>Y</td>
<td>Y</td>
<td>7</td>
<td>8</td>
<td>Y</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>F</td>
<td>39</td>
<td>Y</td>
<td>N</td>
<td>1</td>
<td>13</td>
<td>Y</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>F</td>
<td>56</td>
<td>N</td>
<td>N</td>
<td>6</td>
<td>8</td>
<td>Y</td>
</tr>
<tr>
<td>OB-GYN</td>
<td>F</td>
<td>33</td>
<td>Y</td>
<td>Y</td>
<td>1</td>
<td>12</td>
<td>Y</td>
</tr>
<tr>
<td>OB-GYN</td>
<td>M</td>
<td>48</td>
<td>Y</td>
<td>Y</td>
<td>4</td>
<td>8</td>
<td>Y</td>
</tr>
<tr>
<td>OB-GYN</td>
<td>F</td>
<td>62</td>
<td>Y</td>
<td>Y</td>
<td>13</td>
<td>15</td>
<td>Y</td>
</tr>
<tr>
<td>OB-GYN</td>
<td>M</td>
<td>65</td>
<td>Y</td>
<td>Y</td>
<td>4</td>
<td>14</td>
<td>Y</td>
</tr>
<tr>
<td>Urology</td>
<td>M</td>
<td>71</td>
<td>Y</td>
<td>Y</td>
<td>2.5</td>
<td>4</td>
<td>Y</td>
</tr>
<tr>
<td>Urology</td>
<td>M</td>
<td>72</td>
<td>Y</td>
<td>Y</td>
<td>11</td>
<td>19</td>
<td>Y</td>
</tr>
</tbody>
</table>

*aDid not successfully complete the program.*
of training as invaluable. Most trainees identified having assigned faculty mentors as a major factor in their satisfaction and success. Interaction with residents has been considered beneficial by some trainees, but others have preferred to work one on one with faculty. If trainees do interact with residents, it is important to educate the residents about the purpose of the reentry program.

Program directors report enjoying working with reentering physicians. Trainees with good interpersonal skills are rated highly. Generally trainees fit in and function well with existing teams. Program directors feel strongly that trainees must be able to identify and acknowledge their knowledge deficits and be receptive to feedback. Departments report reimbursement has been adequate to make the program worthwhile to continue.

Discussion

Traditional continuing medical education emphasizes keeping medical knowledge current; however, licensing and credentialing bodies no longer accept completion of a minimum number of hours of CME as sufficient evidence of clinical competence for physicians who have not been active in patient care for more than 2 years. Moreover, physicians themselves wish to be certain they are competent to provide patient care and seek training experiences to prepare to reenter clinical practice. Effective self-assessment is important for ongoing improvement, and the reentry program is one way physicians can improve their self-assessment skills. As increasing numbers of physicians take time off from medical practice for personal and professional reasons, there is a growing demand for training opportunities to prepare them to reenter clinical practice. We have developed an innovative program using a GME model to prepare physicians in good standing to return to independent clinical activity.

To our knowledge, the OHSU program is the only institutional, multispecialty reentry program in the United States where learners have direct and supervised patient care responsibilities during reentry training. We believe a great part of the success of this program relates to the adaptation of the GME model. Initially, faculty members were resistant to working with physicians who had been out of practice for any reason. The most common misapprehension was the faculty’s concern they would be held accountable for “mistakes” made by these physicians in subsequent practice. Reframing the training experience as an extension of graduate medical education allowed the reentering physicians to be covered by the institutional license and malpractice coverage and utilized an educational model with which faculty were experienced and comfortable.

Review of the literature identified only one other reentry program that describes patient care responsibilities—a single-discipline clinical skills program in anesthesiology at the University of California, Los Angeles. There are a limited number of other programs in existence; however, a detailed analysis is beyond the scope of this paper.

The costs of individualized reentry training are difficult to calculate. We have not developed a standardized method to calculate tuition charges and have worked with departments to set their tuitions based on the estimated expense and sophistication of the training provided. Although the cost of this training can be very expensive on a per-person basis, it is capable of returning a physician to full earning capacity in a relatively short period of time, and on a societal level, it is clearly less expensive than training a doctor de novo.

Capacity for training physicians for reentry remains an unanswered question, in large part due to the variability of individual physician needs. We believe OHSU could train 4 reentering physicians a year in internal medicine, pediatrics, family practice, obstetrics and gynecology, and general surgery on its main campus, for a total of 20 physicians a year. Therefore we could potentially increase the output of physicians from our training programs by 10% per year, with most of the reentering physicians returning to primary care.

The OHSU Reentry Program may not be able to prepare large numbers of physicians to reenter practice due to cost and lack of facilities and faculty to train reentering physicians without adversely affecting resident education. Methods of trainee assessment have been variable and have relied heavily on direct observation of clinical skills. Although 13 of 14 graduates are currently practicing direct patient care, we have no long-term follow up to report on their clinical competence beyond completion of their training in the reentry program. Long-term follow up is needed to fully evaluate the effectiveness of the program.

These results are the initial results of a single institution’s intervention; however, we have been able to generalize this model of training across multiple disciplines. The model of training is essentially that utilized by every ACGME-approved residency program, and although further investigation is required, we believe this is a model that could be successfully implemented by any academic medical institution.

In conclusion, although the results of this innovative educational program are encouraging, there are a host of questions that remain unanswered. How much clinical activity is needed to maintain clinical competence and prevent the need...
Lessons for Practice

- Preparing once active clinicians for reentry is one strategy for increasing the physicians workforce, but few reentry programs exist.
- The most common reasons for physicians to seek a reentry training program through the Oregon Health & Science University included expanded scope of practice, recovery from personal illness, and release from family responsibilities.
- Appointing reentering physicians as fellows in graduate medical education facilitated their acceptance by faculty and other learners and provided a method to provide institutional malpractice coverage during their reentry training.
- Thirteen of 14 physicians trained in this hands-on reentry training program are currently employed in active clinical practice.

for reentry training? How long can a physician be out of practice and successfully return to clinical activity? What are the best methods to assess clinical competence in these physicians? What other programs are available to reentering physicians and what can be learned from that combined experience? These questions and more require further investigation and research.

Acknowledgments

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References

13. An Act authorizing the North Carolina Board of Physical Therapy Examiners to require licensees to demonstrate continuing competence in the practice of physical therapy, and strengthening the authority of the North Carolina Medical Board to discipline physicians and certain others, and designating information released to patient safety organizations, public and private, as confidential, and allowing certain groups to practice as professionals, NC Session Law 2006–144, House Bill 1301, §4. G.S. 90–14. Revocation, suspension, annulment or denial of license. (2006).