

Physicians Reentering Clinical Practice: Characteristics and Clinical Abilities

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INTRODUCTION: Limited information exists to describe physicians who return to practice after absences from patient care. The Center for Personalized Education for Physicians (CPEP) is an independent, not-for-profit organization that provides clinical competency assessment and educational programs for physicians, including those reentering practice. This article studies the medical licensure status, performance and correlates between physician characteristics and performance on initial assessment.

METHODS: Sixty-two physicians who left practice voluntarily and without discipline or sanction and who were returning to practice in the same discipline as their previous practice participated in the CPEP reentry program. Physicians completed an objective clinical skills assessment including clinical interviews by specialty-matched board-certified physicians, simulated patient encounters, a documentation exercise and a cognitive function screen. Physicians were rated from 1 (no or limited educational needs) to 4 (global, pervasive deficits). Performance scores were compared based on select physician characteristics.

RESULTS: Twenty-five (40.3 percent) participants were female; participants' average age was 53.7 years (female 48.1 years; male 57.5 years). Physicians left practice for family issues (30.6 percent), health issues (27.4 percent), retirement or nonmedical career change (17.7 percent), and change to medical administration (14.5 percent). Females were more likely than males to have left practice for child rearing ($P < 0.0001$). Approximately one-quarter (24.2 percent) of participants achieved a performance rating of 1 (best-performing group); 35.5 percent achieved a rating of 2; 33 percent achieved a rating of 3; 6.5 percent achieved a rating of 4 (worst-performing group). Years out of practice and increasing physician age predicted poorer performance ($P = 0.0403$, $P = 0.0440$). A large proportion of physicians presenting without an active license achieved active licensure; how many of these physicians actually returned to practice is not known.

DISCUSSION: Physicians who leave practice are a heterogeneous group. Most participants' performance warranted some formal education; few demonstrated global educational needs. The data from this study justify mandates that physicians demonstrate competence through an objective testing process prior to returning to practice. Emerging patterns regarding the performance of the reentering physician may help guide future policy.

Key Words: reentry, return to clinical practice, demonstration of competence, licensure requirements, educational needs, clinical competence, physician workforce, physician shortage, self-assessment

Introduction

The American Medical Association (AMA) suggests that fewer than 10 percent of physicians were on inactive status in 2003;¹ this number rose to nearly 12 percent in 2007.² Physicians leave practice or become clinically inactive for a variety of reasons. Other than actual retirement, the reasons most often cited include care of family members, career and compensation dissatisfaction, health-related problems, pursuit of other careers and sexual harassment.^{3,4}

Following a period of inactivity, some physicians reenter practice. A study of Arizona physicians who renewed their medical licenses between 2003 and 2006 showed that 604 (4.6 percent) reentered clinical practice during this three-year time period,^{5,6} an annual return rate of approximately 1.5 percent. Using this estimate of an annual return rate of 1.5 percent, and an actively employed United States physician population of 661,400 (Bureau of Labor Statistics, 2008),⁷ close to 10,000 physicians may be returning from inactive status each year. State licensure boards as well as hospital and other credentialing bodies are increasingly faced with the question of how to ensure that it is safe to allow these physicians to resume practice.

Many states have addressed concerns about the competence of the reentering physicians by establishing policies that regulate new licensure or reactivation of a medical license after a time away from practice, but these policies vary greatly. Thirty of 68 member boards in the Federation of State Medical Boards (FSMB) responding to an AMA survey⁸ reported that they have a policy regarding physician reentry; an additional nine boards are in the process of developing a policy.⁸ The duration of absence from clinical activity that causes a state licensure board to consider a physician as a reentry physician ranges from 1 to 5 years,⁸ with 2 years or more being the most common criteria. The licensure boards also have varying requirements for the reentry physician to demonstrate competence for licensure, ranging from providing evidence of continuing medical education activity to completion of a formal reentry program.⁸ The reason for this broad array of requirements may be that little is known about precisely how time away from practice impacts physician competency, what risk factors indicate a need for educational

remediation before or while returning to practice, and what kind of educational processes are effective in returning such physicians to practice.

There is limited published information about reentering physicians. The largest previously published study of reentry physicians in the United States is a study of 102 physicians who participated in a Medical College of Pennsylvania program between 1968 and 1976, published in 1978.⁹ A follow-up study published in 1982 from the same program compared the participants from 1968–1975 and 1976–1981, which included a total of 181 participants (including the original 102 physicians).¹⁰ Two studies about retraining such physicians were published in 1969 and 1972.^{11,12} A resurgence of interest in physician reentry surfaced in the early 2000s, as indicated by a flurry of both scientific and lay press articles.^{3,13,14} An article describing a program specifically for anesthesiologists to remediate or update their skills was published in 2006 and reviewed the experience of 25 physicians.¹⁵ Respected professional organizations such as the American Academy of Pediatrics (AAP) and the AMA have expended effort gathering expertise and composing recommendations related to this topic. The AAP Division of Workforce and Medical

PHYSICIANS WHO LEAVE PRACTICE FOR A PROLONGED BREAK ARE A HETEROGENEOUS GROUP, THE MAJORITY OF WHOM DEMONSTRATE EDUCATIONAL NEEDS THAT WARRANT SOME STRUCTURED EDUCATION BEFORE REENTERING PRACTICE.

Education Policy is the guiding force behind the Physician Reentry into the Workforce Project, a collaboration of several organizations that focuses on issues pertinent to reentering physicians (<http://www.physicianreentry.org/>). In 2008, the AMA Council on Medical Education released a report on physician reentry, which provided an overview of the status of reentry in the United States as well as 10 proposed guiding principles for physician reentry programs.⁵ Notably, these guiding principles included a recommendation that the reentry programs have an objective mechanism to evaluate physician performance and that the programs are tailored to the needs of the individual physician.

The Center for Personalized Education for Physicians (CPEP) is an independent, not-for-profit organization founded in 1990. CPEP provides clinical competency assessments and educational programs for

physicians, including those returning to practice after an absence. CPEP programs are structured on the premises that education should be directed by an evaluation of the individual’s educational needs^{16,17} and that traditional continuing medical education conferences alone may not be effective in improving practice.¹⁸ This approach is consistent with that of remediation programs both in the United States and internationally.^{17,19} Since 2003, CPEP has evaluated 62 reentry physicians and has assisted many of those who needed remediation through a structured educational process. This article describes the characteristics, participant performance, and licensure status of those physicians, and potential correlates among physician characteristics and between physician characteristics and performance on initial assessment. Finally, this article will discuss whether the performance ratings of these reentering physicians support licensing board requirements to demonstrate competence after a time away from practice.

Methods

The CPEP Reentry Program involves an initial skills assessment in the physician’s area of intended practice and, if education or remediation is indicated, a supportive and structured educational process that takes place while the physician returns to practice. CPEP evaluated 62 reentry physicians and assisted a portion of those who needed remediation through a structured educational process. All participants in

this study were physicians (M.D. or D.O.). Physicians were eligible for this study if they left practice voluntarily, were under no state licensure board discipline or sanction, and were returning to practice in the same discipline as their previous practice.

At the time of enrollment, participants (*n* = 62) provided demographic information (gender, age), information about their licensure status, and information about their professional status (reason for leaving practice and time away from practice) with the use of self-report forms; if information in the written intake form was unclear or missing, CPEP staff clarified the information through discussion with the participant. Licensure status was tracked because most of the participants enrolled to comply with a board rule to demonstrate competence, and the immediate objective of these participants was to gain licensure or relicensure. CPEP confirmed the licensure status at the time of enrollment as well as current licensure status (May 2010).

The physicians completed a clinical skills assessment that included 2–3 90-minute interviews conducted by specialty matched board-certified physician consultants. In addition, the participants completed two (psychiatry) or three (all other specialties that involve patient contact) simulated patient encounters, a documentation exercise, cognitive function screen and, depending on the physician specialty, written testing. The number of interviews conducted varied due to changes to the reentry protocol as it evolved over time, and due to

Table 1
Factors considered in determining participant rating and description of educational processes

Factors considered	Performance rating			
	1	2	3	4
Demonstrated readiness for practice	Yes	Yes, with educational support	Yes, with initial period of supervision	No
Extent of educational needs	None to minimal	Moderate	Extensive	Global
Recommended educational process	Independent on-going education	Preceptorship (case discussion, chart review)	Comprehensive specialty review	Training in residency setting
		Focused study (article review, CME)	Initial supervised practice (gradually increasing responsibility)	
		Medical information resources (Internet, hand-held devices)	Activities as described for rating 2	
Estimated duration of educational process	N/A	Two–four months	Four–nine months	Determined by residency

a specific request by a referring state medical board that applicants who had been out for more than 10 years undergo a more rigorous evaluation because of the length of time out of practice; CPEP ultimately adopted this protocol and began to recommend three interviews for physicians who had been out for more than 10 years. Of the 14 physicians in this study who had three clinical interviews, 10 were physicians who had been out of practice for more than 10 years; the other four underwent three interviews for reasons determined by CPEP. Forty-eight physicians completed two clinical interviews, including five participants who had been out of practice for more than 10 years. Factors considered in determining the performance ratings were demonstration of readiness for practice and the extent and characteristics of educational needs identified. Two CPEP physician reviewers and the Executive Director reviewed the data from each participant and reached concurrence regarding the factors.

Those physicians who demonstrated readiness to return to independent practice were rated a 1; physicians with global educational deficits needing residency education were rated a 4. Physicians rated 2 and 3 demonstrated moderate to extensive educational needs; for these physicians, CPEP recommended completion of a structured educational process, which might include focused study, coursework, preceptorship, or chart review. The primary difference in these ratings is that the latter had more extensive educational needs and, thus, more intensive education was recommended, including initial practice in a supervised setting with gradually

increasing independence. The factors considered in determining the performance rating and a brief description of the potential educational recommendations are elaborated in Table 1. A portion of the participants who completed the assessment component enrolled in the education component of the reentry program. SAS version 9.2 (The SAS Institute, Cary, NC) was utilized for all statistical tests. Fisher’s exact tests were performed (see Table 2) to relate primary reason for leaving practice to gender. Reason for leaving practice was coded as a dummy variable for this analysis (0,1), and a

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separate test was run for each reason for leaving practice. In Tables 3 and 4, one-way analyses of variance (ANOVAs) utilizing the general linear models were employed to test the relationship between physician rating, time out of practice, and age. A multi-variate model was not tested because time out of practice and age were highly collinear variables. Fisher’s exact test was performed to evaluate licensure status at the time of the initial assessment and assessment performance.

Table 2
Primary reason reported for leaving clinical practice by gender

Primary reason for leaving practice	Female	Male	Total number of participants	P value* (Fisher’s exact)
Administrative position	1	8	9 (14.5%)	0.0716
Personal: child rearing	14	3	17 (27.4%)	<0.0001
Personal: care of spouse	1	1	2 (3.2%)	1.00
Health: medical	6	8	14 (22.6%)	1.00
Health: psychiatric	1	2	3 (4.8%)	1.00
Nonmedical career	0	3	3 (4.8%)	0.2663
Personal: other	1	5	6 (9.7%)	0.3870
Retired	1	7	8 (12.9%)	0.1286
Total	25	37	62	

*P value relating gender to primary reason for leaving practice.

Results

Description of participants

Twenty-five (40.3 percent) of the participants were female. Ages of the participants ranged from 31 to 73 years, with an average age of 53.7 years (female 48.1 years; male 57.5 years). The majority of the participants (49 or 79 percent) enrolled in the reentry program in order to demonstrate competency after time away from practice for a state licensure board; some came at the recommendation of a hospital (4, 6.5 percent) or other organization (4, 6.5 percent), and some were self-referred (5, 8.1 percent). The majority (46 or 74.2 percent) of physicians had either an inactive/lapsed/expired license or no license in the state in which they wished to enter practice at the time of enrollment.

Participants left practice for a variety of reasons, such as family issues including care of family members (30.6 percent) [child-rearing 27.4 percent; care of a sick spouse 3.2 percent], health issues (27.4 percent), retirement or leaving medicine to pursue a different career (nonmedical career change [17.7 percent]), and to assume a medical administrative position (14.5 percent) (see Table 2). When comparing reasons for leaving practice to gender, the data showed that females were more likely than males to leave practice for child-rearing purposes ($P < 0.0001$). The association between leaving for an administrative position and gender approached significance ($P=0.072$) with males choosing this route more often than females.

The time out of practice averaged 8.1 years, and ranged from 1.5 years to 23 years. Participants were preparing to return to a variety of specialties, including primary care (internal medicine, family

medicine, pediatrics, and general practice) (48.4 percent), surgery and surgical specialties (14.5 percent), psychiatry (9.7 percent), obstetrics/gynecology and subspecialties (6.5 percent), internal medicine subspecialties (6.5 percent), anesthesiology (4.8 percent), and others (9.7 percent).

Participant performance

Approximately one-quarter of participants (15, 24.2 percent) achieved a performance rating of 1 during their assessment; 69.4 percent demonstrated a performance rating of 2 (22, 35.5 percent) or 3 (21, 33.9 percent), and a small portion of the participants (4, 6.5 percent) achieved a performance rating of 4. Participant performance was also analyzed based on time away from practice and the results are shown in Table 3. Years out of practice was significantly related to performance rating ($P = 0.0403$).

Physician performance ratings were also analyzed based on participant age category (see Table 4). Physician age category was significantly related to performance rating ($P= 0.0440$) with older physicians more likely to have higher ratings. There was no significant relationship between licensure status at the time of the assessment and performance in this small data set ($P = 0.4641$).

Licensure status and practice outcomes

Licensure status was determined based on the state in which the physician reported that he/she intended to seek licensure or practice. Licensure status at the time of presentation was compared to current licensure status (May 2010). CPEP was able to confirm the accuracy of the self-reported status for 46 (74.2 percent) of physicians; because of the

Table 3
Rating on assessment by years out of practice: range of performance and average rating

Years out of practice	Number of participants to achieve each rating				Total	Average rating
	1	2	3	4		
1–5 years	7 (36.8%)	5 (26.3%)	7 (36.8%)	0	19	2.00
6–10 years	6 (21.4%)	13 (46.4%)	7 (25%)	2 (7.1%)	28	2.18
11–15 years	2 (20%)	2 (20%)	5 (50%)	1 (10%)	10	2.50
>16 years	0	2 (40%)	2 (40%)	1 (20%)	5	2.80
Total	15	22	21	4	62	2.23

Note: Years out of practice is significantly related to physician rating ($P = 0.0403$) with the use of a general linear model in SAS version 9.2.

way licensure status is recorded on some board Web sites, CPEP was not able to confirm initial status for the remaining 16 physicians. CPEP staff confirmed the current (May 2010) licensure status for all physicians. Licensure status is presented in Table 5.

At this time, CPEP does not know whether physicians who did not have continued involvement with CPEP education programs have actually returned to practice. For the 22 physicians who enrolled in the education component of the reentry program, 16 completed their educational process, and each of these physicians was in active practice during and at the completion of the educational process. An additional three physicians are currently enrolled, two of whom are actively engaged in practice. Three physicians withdrew prior to completion of the program.

Discussion

The authors believe that this article provides information about the largest series of reentering physicians since the description of physicians reentering practice through the Medical College of Pennsylvania program, published in 1982.¹⁰

CPEP’s assessment of reentry physicians indicates that physicians who leave practice for a prolonged break are a heterogeneous group, the majority of whom demonstrate educational needs that warrant some structured education before reentering practice. In this data set, approximately two-thirds of participants currently have active licenses in comparison to 25 percent at enrollment, indicating that they have been able to address licensing board requirements. Most of the physicians who completed the education components and for whom follow-up data were available achieved their stated goal of returning to practice.

Characteristics of reentry physicians and their reasons for leaving practice

Among CPEP reentry program participants, approximately 12.9 percent left practice intending to retire, whereas 4.8 percent left medicine to pursue a nonmedical career. Another 14.5 percent left practice for a nonclinical medical administrative role. Male physicians *may* be more likely to leave for a medical administrative role than females. Seventeen percent of participants cited child rearing as their reason for leaving practice. Female physicians in this group were statistically more likely to leave practice for child rearing than their male counterparts.

Physical and mental health conditions are cited as reasons that physicians might require prolonged absences from clinical practice. CPEP findings were similar to a study of Australian nurses returning to practice, in which health of the individual or a family member was implicated in 16 of 69 cases (23.2 percent).²⁰ In the CPEP study, 27.4 percent of physician reentry candidates indicated that personal health conditions were the reason that they left practice. The majority of the health conditions were physical health conditions including stroke, closed head injury, and multiple sclerosis, rather than mental

Table 5
Licensure status

Performance rating	Active license at enrollment		Active license May 2010	
All participants	16	(25%)	41	(66%)
1	5	(33%)	14	(93%)
2	4	(18%)	15	(68%)
3	5	(24%)	11	(52%)
4	2	(50%)	1	(25%)

Table 4
Rating on assessment by participant age

Age	Number of participants to achieve each rating				Total	Average rating
	1	2	3	4		
30–39 years	1 (20%)	2 (40%)	2 (40%)	0	5	2.20
40–49 years	6 (40%)	6 (40%)	3 (20%)	0	15	1.80
50–59 years	4 (16%)	11 (44%)	10 (40%)	0	25	2.24
60–69 years	3 (25%)	3 (25%)	5 (41.7%)	1 (8.3%)	12	2.33
70–79 years	1 (20%)	0	1 (20%)	3 (60%)	5	3.20
Total	15	22	21	4	62	2.23

Note: Age category is significantly related to physician rating (P = 0.0440) with the use of a general linear model in SAS version 9.2.

health conditions. Psychiatric conditions included depression and substance abuse. CPEP excluded physicians from the program who had disciplinary board stipulations or orders; therefore, physicians who had discipline related to health conditions such as substance abuse were excluded from this study.

Participant performance

Approximately one-quarter of the physicians who completed the clinical skills assessment demonstrated minimal educational needs and were adequately prepared for a return to independent practice at the time of the assessment. The majority (67 percent) were found to have educational needs requiring moderate to considerable reeducation or updating and another 6.5 percent showed educational needs that were broad enough to recommend education in a residency program to prepare for a return to practice (performance rating of 4). These data tend to confirm the concern of licensure boards that many reentering physicians may not be ready to jump back into practice; they also tend to justify mandates that physicians demonstrate competence through an objective testing process prior to returning to practice.

Participant licensure and return to practice

The primary reason that physicians enrolled in the CPEP Reentry Program was to meet state board licensure requirements. This study found that many of the participants who presented to the program without an active license went on to obtain a license. This study did not include specific follow-up with participants to determine whether they actually returned to practice. There was a relatively small subset of physicians who participated in a structured educational process with CPEP and for whom data were available to suggest they were successful in returning to practice. It is not yet clear whether a physician's demonstrated abilities and readiness to return to practice can be predicted. Other studies have shown a correlation between increasing age and poor performance on competency assessment in different physician populations.^{19, 21-23} The data presented here support similar conclusions for the reentry physician population. This data also indicate that time away from practice correlated with worse performance. If additional studies confirm these trends, licensing boards may choose to consider varying requirements, based on time away from practice and/or the age of the physician. Interestingly, there was no significant relationship between initial license status at the time of presentation and performance in this dataset; thus, having an active license at the time of reentry did not correlate with better performance in the CPEP program. This may be relevant as

boards begin to consider how to regulate the inactive physician who has maintained an active license.

Limitations

This study is limited by the relatively small number of physicians studied, which may have impacted the ability to identify statistical significance with some variables. Some of the physician characteristics reported are self-reported, such as the reason for leaving practice. The extent of educational activities undertaken by the participant prior to enrollment was not evaluated. Although CPEP encouraged participants to prepare prior to the reentry assessment, this was left up to the individual participants. Therefore, the authors cannot comment on the possible impact of individual preparation on performance. With consideration for the developing nature of the CPEP process, including individualization of assessment, each physician did not undergo exactly the same evaluation process, such as two versus three interviews. CPEP utilizes oral interviews in the evaluation of physicians, which allows for tailoring an evaluation to the physician; such interviews can be criticized due to potential subjectivity. CPEP strives to address this in its training processes and assessment structure.

Implications

Physicians have been shown to be poor at analyzing their educational needs, and the more significant the physician's needs, the more significant the discrepancy in self-perceived versus actual educational needs.²⁴ This suggests that it may be difficult for physicians returning to practice to plan for and gauge their

Lessons for practice

- Through an objective assessment of competence, physicians returning to practice can be assisted in identifying gaps in knowledge prior to their return to patient care.
- A majority of participants who enrolled in the Center for Personalized Education for Physicians (CPEP) reentry program demonstrated moderate to significant educational needs.
- Physicians who participated in a supportive, structured educational program were generally successful in achieving their goal of restoring licensure and returning to practice.
- Emerging patterns indicate that certain physician characteristics (age, time away from practice) may help predict performance.

readiness for return accurately. Licensing board mandates that require a reentry physician to demonstrate competency through an objective assessment process prior to consideration for licensure or reactivation of licensure, and to follow through with educational recommendations, create barriers of time and cost for the reentering physician. However, the first priority of the licensing boards is patient safety, and the boards must create policies that are consistent with the mission of ensuring the competence of licensees.²⁵ Assessed competency with educational recommendations appears justified, based on the findings of this study. Further analysis of potential correlates with performance may allow more tailored approaches based on physician characteristics or circumstances.

Unanswered questions and future research

Especially in light of growing concerns about the physician workforce,^{26,27} the issue of physicians returning to clinical practice after a prolonged absence is of major importance. The magnitude of the phenomenon of physician reentry is uncertain, but it may include thousands of physicians each year. Though many state licensure boards and hospitals have established policies to manage reentry physicians, the policies vary significantly from state to state regarding the duration of absence from practice that would trigger a reentry process, acceptable options to demonstrate competence, and the educational process required prior to licensure or reactivation.⁸

It is not yet clear whether a physician's demonstrated abilities and readiness to return to practice can be predicted, but data from this study show a relationship between time away from practice and increased age and poorer performance. Additional study is warranted to learn more about the reentry physician and potential predictors of performance.

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