Physician Reentry: Results of a Post-Program Survey

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ABSTRACT: In the United States, clinically inactive physicians are asked to demonstrate refreshed skills and knowledge for relicensure or recredentialing. Limited data exists about these programs' outcomes and participants' perspectives. Our survey results from physicians who completed a reentry preceptorship program in the United States will help better guide how programs can be tailored to fit reentry physicians' goals. Physicians who completed a reentry program between November 2006 and April 2013 were asked to complete an anonymous survey, with 50 of 64 physicians responding (78% response rate). Most were men, 41–59 years of age, board certified, self-referred, unemployed, with an active medical license, and reporting a median eight years of clinical inactivity. Physicians' top three goals for participating in the program were clinical employment, regaining their medical license, and refreshing their skills. A majority (n=37, 74%) achieved their primary goal within a year of program completion. Most reported that the course prepared them for their current work and resolved challenges of reentry, including improvement in their confidence, medical knowledge and clinical skills. This is the first paper looking at returning physicians' perspectives about their refresher/reentry program experience and outcomes. This survey helps reentry programs better understand their participants' views to provide valuable training, mentoring and placement counseling.

Introduction

Physicians' careers may be unexpectedly interrupted for a variety of reasons, including caretaking, career dissatisfaction, personal or family illness, and alternative careers.[1] A physician license survey performed by the American Medical Association (AMA) showed that 58% of state licensing boards (33 out of 57 respondents from 65 boards) have a policy on physician reentry for physicians who left active practice and want to re-enter practice.[2] Many states have regulations that also require taking and passing the Special Purpose Exam (SPEX) or a similar exam. In addition to examinations, when clinically inactive physicians decide to return to practice, they often also face additional personal, professional and institutional challenges.[3] The barriers they face are many and include lack of a uniform reentry system in the United States, geographic distance to available reentry programs, differences among states' medical licensing regulations and individual barriers — including lack of information about reentry and substantial cost.[4]

IN ADDITION TO EXAMINATIONS, WHEN CLINICALLY INACTIVE PHYSICIANS DECIDE TO RETURN TO PRACTICE, THEY OFTEN ALSO FACE ADDITIONAL PERSONAL, PROFESSIONAL AND INSTITUTIONAL CHALLENGES.

In response to an increasing need for refresher programs for returning physicians, Drexel University College of Medicine in Philadelphia relaunched the Drexel Physician Refresher/Reentry Program in November 2006, based on its 1968–1994 predecessor program at the Medical College of Pennsylvania.[5,6,7] This program provides inactive physicians with a structured yet personalized and flexible refresher/re-education program to bring their skills up-to-date for their individual needs.

After reviewing the literature, we noted that there are only a few studies on physician re-education.[8, 9, 10, 11, 12] None provides follow-up data after program completion, or quantifies success in return to clinical activity, nor do any studies report physicians' perspectives about their programs. These outcomes are important, as health care licensing organizations[13, 14, 15, 16] ask physicians to seek re-education without supporting evidence about the re-education's impact. This paper will add to the existing body of knowledge on physician reentry by examining physicians' perspectives on their refresher education, challenges and attainment of goals to return to practice, in order to provide more effective training.

Methods

Program Description

Reentry/Refresher programs were developed to assist clinically inactive physicians wishing to return to medical practice to refresh their skills and

knowledge. The Drexel Medicine Physician Reentry/Refresher Program in Philadelphia enrolls physicians who have left practice for all reasons, including reentry and remediation. The AMA defines physician reentry as "a return to clinical practice in the discipline in which one has been trained or certified following an extended period of clinical inactivity not resulting from discipline or impairment."[17] Remediation involves physicians who have been disciplined, are impaired and/or have been mandated to seek further training because of gaps in knowledge or skill.[18] Regardless of the cause for not practicing medicine, inactive physicians need to refresh their skills and knowledge before returning to practice. The curriculum seeks to bring physicians' medical knowledge and skills up-to-date through a comprehensive, self-paced, self-selected didactic curriculum and a structured preceptorship, customized to their needs. Duration varies, based on initial and interim assessments every six weeks. A detailed description has been previously published.[12]

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The program director and trainee use the physician's self-assessment information, including personal future-practice goals, the referring body's guidance and various independent pre-assessment exams to develop a mutually agreed upon and individualized curriculum. Assessment tools are multi-sourced and include knowledge, communication, and performance. The program director, staff and preceptor regularly seek verbal and written feedback and elicit ideas for improvement from physician trainees to ensure that trainees are achieving their learning goals. Trainees receive extensive technologic training, individualized mentoring, career and emotional counseling as needed and tools to develop lifelong learning habits.

Post-Program Physician Survey

The authors created and electronically distributed a detailed survey to the initial cohort of 64 physicians who completed the program between November 2006 and April 2013.

This survey included questions on physician demographics, reasons for leaving clinical medicine, length of clinical inactivity, employment and challenges faced when attempting to return to medicine. Physicians were also asked to identify a primary goal they wished to attain upon program completion and whether the program helped them attain this goal and in what time frame did they achieve the goal.

This study received an Institutional Review Board exemption. The participants were given an instruction sheet explaining the research study, risks and benefits, anonymity of the result, the subject's right to withdraw consent and a statement that they would receive no payment for their participation.

Results

Sixty-four of 66 physicians who completed the course, between November 2006 and April 2013, consented to be included in the study. Two physicians who did not provide consent cited privacy issues as their reason for non-inclusion. Fifty of 64 physicians returned the study survey (78% response rate) after an average of three email requests.

Table 1 lists demographics of physicians who returned the study survey. Most respondents were men (n=32, 64%) between the ages of 41 and 59 (n=39, 78%), board-certified (n=34, 68%), with an active medical license (n=44, 88%.) Of the six (12%) physicians without a medical license at the start of the program, four (1%) had suspended licenses (two for substance abuse, one for financial fraud, another for medical negligence) and two had not sought renewal. The median number of years away from clinical practice was eight. Female physicians reported a longer median interval of clinical inactivity compared to male physicians (10 vs. six years, respectively). Of the physicians' refresher tracks, 35 were internal medicine,

Table 1
Physician Demographics

	Male	Female	Total n (%)
Gender	32 (64%)	18 (36%)	50 (100%)
Age (range): 1-40	0	1	1 (2%)
41-59	24	15	39 (78%)
60 and over	8	2	10 (20%)
Board Certification	21	13	34 (68%)
Active Medical License	28	16	44 (88%)
Years away from clinical practice Median (range)	6 (0–15)	10 (3–22)	8 (0–22)

Table 2
Physician Specialty Refresher Track Completed

Internal Medicine	35 (70%)
Obstetrics/Gynecology	6 (12%)
Surgery	5 (10%)
Pediatrics/Medicine	1 (2%)
Pediatrics	2 (4%)
Anesthesia	1 (2%)

six were obstetrics/gynecology, five were surgery, one was both medicine and pediatrics, two were pediatrics and one was anesthesia (Table 2).

Physicians reported several reasons for leaving clinical practice. Family issues were the most common reason cited (24%). The other causes, in decreasing order, were disciplinary action, illness, non-clinical employment and malpractice insurance costs. Of the 12 physicians who reported family issues as their reason for leaving, 10 were women

PHYSICIANS REPORTED SEVERAL REASONS FOR LEAVING CLINICAL PRACTICE. FAMILY ISSUES WERE THE MOST COMMON REASON CITED (24%). THE OTHER CAUSES, IN DECREASING ORDER, WERE DISCIPLINARY ACTION, ILLNESS, NON-CLINICAL EMPLOYMENT AND MALPRACTICE INSURANCE COSTS.

and two were men. Since this program also included remediating physicians, the survey demographic included 22% (n=11) who left clinical practice because of disciplinary action or impairment. Physicians who reported discipline as their reason for leaving medicine further specified the causes as chemical dependence (n=4), depression (n=2), and other disciplinary issues (n=5). Of note, although physicians may have left medicine for disciplinary issues, their licenses were not always revoked. Also, at the time of their seeking a reentry program, they had already addressed and resolved their primary medical and legal reasons for departure.

Referrals to the program were through various channels. Of the 50 physicians who responded to the survey, 30 (60%) were self-referred and nine (18%) were referred by their state boards. Other sources of referral included employers, residency directors or attorneys. Prior to the start of the program, 36% (n=18) reported that they were

Table 3
Employment Statistics Prior to Starting Course

	Male	Female	Total
# Employed Prior to the Course	13	5	18 (36%)
Clinical employment	6	1	7 (14%)
Industry	2	0	2
Administration	3	2	5
Other	2	2	4
Unemployed	28	4	32

employed; in this group, less than half (n=7, 14%) were practicing in a clinical setting. Other types of employment included industry and medical administration (Table 3). After the program, physicians reported a fourfold increase in clinical employment (n=28 of 50, 56%.) Sixteen of these 28 physicians practiced in an outpatient setting, while 10 practiced in both inpatient and outpatient settings; eight identified their practice as being in a rural setting.

We asked physicians to identify their primary goal in participating in the reentry/refresher program. The most frequent goal selected was obtaining clinical employment (n=18, 36%). Other primary goals identified included regaining a medical license, refreshing clinical skills, gaining hospital privileges and obtaining a residency position (Table 4). Overall, 37 (74%) physicians reported they had achieved their primary goal after completing the program. Eleven of the 18 physicians who selected clinical employment as their primary goal were successful. Of the 12 who stated that regaining their medical

Table 4
Trainees' Selected Primary Goal for Taking the Refresher Course

Goal	N (% out of 50 respondents)	Achieved N (% out of those seeking the goal)
Clinical Employment	18 (36%)	11 (61%)
Regain Medical License	12 (24%)	10 (83%)
Refresh Skills	12 (24%)	10 (83%)
Gain Hospital Privileges	5 (10%)	5 (100%)
Attain Residency	3 (6%)	1 (33%)

license was the primary goal, 10 were successful (83%). All five (100%) who stated that gaining hospital privileges was their primary goal were successful. Ten of 12 (83%) succeeded at their primary goal of refreshing skills and one of three (33%) who wanted to attain residency was successful.

Thirteen (26%) physicians reported that they had not met their primary goal after completion of the program. These physicians reported a variety of reasons for not achieving their primary goal, including: "had not yet applied for employment or a medical license," "employers indicated that they needed more patient contact," and "needing more time to hear back" from programs/jobs, as they had finished the program in less than 12 weeks prior to completing the survey.

We asked physicians about the challenges they faced in returning to clinical work and how our program helped them overcome these challenges. These challenges (categorized and listed in descending order) were lack of skills and knowledge, lack of peer support/network, lack of confidence, inability to find employment, obtaining malpractice insurance, inability to return to clinical practice, lack of experience in patient care and length of time out of medicine. Most (79%) reported that the program prepared them to effectively resolve these challenges by (in descending order) improving their clinical skills, confidence, medical knowledge, interest and focus in medicine. In an open-ended question format, physicians were then asked to specifically comment on how the program changed their clinical practice. Statements included, "improvement in their confidence to practice medicine" and "updating knowledge content." In addition, they noted improvement in their communication skills, which included how to receive and provide feedback, adding empathy and updating communication skills in motivation and shared decision making. Other skills reported by participants as being useful were exposure to recent technology and strategies for lifelong learning. In particular, they liked learning computer and library search skills. In addition, they noted increasing comfort with electronic medical record use as well as exposure to new medical procedures. The program used a dedicated information technologist to help physicians learn computer skills — to access updated medical information as well as improve touch-typing and dictation skills.

...SKILLS REPORTED BY PARTICIPANTS AS BEING USEFUL WERE EXPOSURE TO RECENT TECHNOLOGY AND STRATEGIES FOR LIFELONG LEARNING. IN PARTICULAR, THEY LIKED LEARNING COMPUTER AND LIBRARY SEARCH SKILLS.

Some of the written comments in the survey mentioned how a program dedicated to returning physicians helped in a more global manner to increase confidence:

> *"Reentry Program offers doctors out of practice unique opportunities to participate in clinical experience, an intensive small group clinical learning, great support group and resources for learning. The training assisted me to obtain an unrestricted medical license and a job to practice medicine."*
>
> — Internist

> *"If you are not in medical practice for a long time, it makes you a little uneasy to come back again. I think this course is a good remedy for that. The program gave me a sense of security, encouragement and support, and that helped."*
>
> — Pediatrician

Discussion

This paper contributes to the modest body of research about physician re-education by directly using a post-program survey to report physicians' demographics, their perspectives concerning their professional goals in participating in a reentry program, satisfaction with the reentry program curriculum and self-reported data on post-program employment and placement outcomes.

The survey results from 50 physicians who completed this reentry program included data from our first seven years' experience from 2006 to 2013. Our data supports other published data showing that men constitute the majority of reentry/refresher program trainees.[10] The results of our survey confirm the small body of published research reporting that physicians left clinical medicine for a variety of reasons, including career change (including early retirement), family caretaking, personal or family illness and career dissatisfaction.[1] Our study supports findings that more women than men left clinical practice for family reasons.[10] This post-survey data is an added tool for physicians who contemplate taking time off from clinical

medicine and stakeholders who develop or require reentry programs. Understanding the consequences of becoming inactive clinically would allow physicians to strategize before departure from medicine. Ideas such as job-sharing, part-time work, and longer family leave have been supported by the American Academy of Pediatrics to support the female physician workforce.[15]

This survey also examined the perspectives of inactive physicians to highlight their primary goals before entering a reentry program. The survey showed that these goals centered around clinical employment (36%), regaining a medical license (26%) and refreshing skills (24%). It is not surprising, given these goals, that most of the participants (both male and female) were unemployed prior to the course. AAMC Physician Workforce projections anticipate workforce shortages with longer waits for appointments and unfilled positions for doctors in primary care and specialties.[19] Refresher courses for physicians may help with this workforce shortage. At the end of the survey period, 56% of the 50 respondents stated that they were clinically employed. Most of these 28 physicians practiced in an outpatient setting, while 36% (n=10) of them

OUR REENTRY PROGRAM INCLUDED NOT ONLY UPDATING SKILLS AND KNOWLEDGE, BUT ALSO INFORMAL COUNSELING SESSIONS TO BUILD PHYSICIAN CONFIDENCE, HELP GUIDE "NEXT STEPS" AND CONNECT WITH RECRUITERS AND OTHER JOB-PLACEMENT INTERFACES.

practiced in both inpatient and outpatient settings; 29% of them (n=8) practiced in a rural setting, which traditionally experience physician shortages.

Of the 13 who did not achieve their goal within the first year of completing the refresher course, most reported difficulty in procedural issues related to either employment or relicensing or the need to gain more experience. This feedback helps us strategize when working with returning physicians to immediately involve employers or state boards at the beginning of the physicians' re-education. Another strategy could be to keep these organizations abreast of individuals' reentry-plan progression to expedite physicians reaching their goal(s). Participants also noted the almost insurmountable paperwork during the hiring process; again, their feedback is valuable to help others start their process early. With this information, we can provide anticipatory guidance to reentering physicians that employment may be delayed and that physicians should strategize early, actively seek positions, start applications and inform credentialing committees or boards of their reentry intent and progress.

Our reentry program included not only updating skills and knowledge, but also informal counseling sessions to build physician confidence, help guide "next steps" and connect with recruiters

UNDERSTANDING THE CONSEQUENCES OF BECOMING INACTIVE CLINICALLY WOULD ALLOW PHYSICIANS TO STRATEGIZE BEFORE DEPARTURE FROM MEDICINE.

and other job-placement interfaces. This type of mentoring and support continued even after the program, with reference letters and follow-up emails. Physicians' survey results support reentry programs' use of these ancillary support systems to help physicians better cope with employment and relicensing processes.

Limitations

The physicians in our study may not be representative of the general pool of all returning physicians in all parts of the United States. The sample size of physicians is small (50), data is limited to one program and looks only at clinically inactive physicians who pursue a refresher course. The study does not compare differences between this target group and inactive physicians who do not pursue re-education. The response rate of 78% is significant; however, there were instances when respondents did not respond to the open-ended questions or questions.

Due to the small sample size and anonymity of survey results, we could not differentiate responses by specialty, reasons for return to practice, nor work quality upon return. Future studies could measure these characteristics as well as the performance outcomes. We hope to use our second cohort from 2013–2020 for further studies.

Despite these limitations, we believe our findings are an important addition to the currently limited data on reentry programs. We anticipate more research in this important area.

Lessons for Practice

1. Female physicians cited family issues as the most common reason for leaving medical practice.
2. Physician goals upon entering a reentry program centered around clinical employment, regaining medical license and refreshing skills.
3. Prior to starting a reentry program, in order to achieve desired outcomes, ask physicians to clearly, and in detail, list their goals and needs for embarking on a reentry plan of study.
4. Help reentering physicians understand and anticipate their future needs and challenges for employment and relicensure. ■

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