Out of Practice: Doctors Find Challenges Up

—By Sarah Mann

Eight years ago, Thomas Eberly, M.D., 54, an internist in Oregon, found himself experiencing burn out as a primary care provider, mainly due to the seemingly never ending treadmill of patients and paperwork. Eberly left clinical practice to work in health IT, but after the company shifted its focus a few years back, Eberly felt a pull to treat patients again. The only problem was, he was unsure just how to go about returning after so much time in another field.

"I'd been away a long time. The field had changed a lot," Eberly said. "I didn't think I could just do some reading and feel ready to return."

Eberly is emblematic of an emerging class of health practitioner: the reentering physician. Doctors leave their practice for many reasons and stay away for various lengths of time. The flip side is that many factors are also driving them to return to clinical practice. However, Eberly and countless others have found it is not as easy as simply walking back into the doctor's office and calling out "next."

Different states and hospital authorities classify a reentering physician as someone who has been away from practice from anywhere from one to five years—and the current system for bringing physicians back up to speed is fragmented at best. Given a changing health care system and a widely predicted physician shortage, particularly in the primary care specialties, some groups and health care leaders are taking a fresh look at the needs of the reentering physician.

Complete and reliable data on the number of doctors seeking to return to medical practice after significant time away are lacking, making it difficult to determine whether the number of reentering physicians is increasing, according to Carol Aschenbrener, M.D., AAMC executive vice president.

In any case, more physicians and groups than ever seem to be discussing reentry, said Holly Mulvey, M.A., director of the Physician Reentry into the Workforce Project (PRWP) spearheaded by the American Academy of Pediatrics (APA).

New requirements from licensing and medical specialty boards may also be focusing more attention on reentering physicians, as more boards are requiring these doctors to demonstrate that they have kept up with clinical knowledge during their absences. Some hospital associations have contacted groups like the PRWP to ask how they can be sure reentering physicians are capable of providing high-quality care. This increased scrutiny could be pushing more physicians to participate in some type of training before reentering.

"Documentation of physicians' ability to treat patients is becoming more of a big deal," Aschenbrener said. "Even nonretired physicians who are moderately active clinicians may need to increase their patient hours to keep practicing. For people who have exited the field, demonstrating clinical competency will be even more important."

Several factors can contribute to a physician's decision to leave—and later return to—clinical medicine, said Mulvey. Family responsibilities, personal illness, career dissatisfaction, new career opportunities in administration or research, and retirement can all take people away from practice, she said. A University of Arizona (UA) study found both men and women leave and reenter practice, though 75 percent of reentering physicians in the study were men. Additionally, over the past year, many retired physicians have had to go back to work out of necessity, because the poor economy depleted nest eggs, Mulvey said.

The AAMC Center for Workforce Studies has projected a shortage of more than 150,000 physicians by 2025. While reentering physicians could help address the projected shortage, it is crucial that reentering physicians are able to provide high-quality care, said Aschenbrener.

According to the Federation of State Medical Boards, two states—Colorado and North Carolina—require physicians who have been out of practice for two years or longer to demonstrate that they have kept current on clinical knowledge. The Colorado Board of Medical Examiners requires physicians who have not actively practiced for two years or longer to submit an evaluation from a reentry program before obtaining an unrestricted license. In North Carolina, a 2006 law requires doctors to inform the North Carolina Medical Board (NCMB) what they have done to keep their skills sharp. If NCMB decides the physician needs additional training, the physician must develop his or her own educational plan, which typically includes following a mentor or fellow physician for a predetermined amount of time, according to NCMB spokesperson Jean Brinkley. The mentor submits regular reports on the reentering physician's progress, and upon approval of the board and the mentor, the physician can return to practice.

on Return to the Fold

Eberly, the reentering internist, said he did not receive pressure from a medical board, but nevertheless did not feel comfortable jumping right back into practice. He discovered the Interinstitutional Physician Reentry Program at Oregon Health and Science University (OHSU), in which prospectively reentering physicians take part in a highly structured refresher program, said Elizabeth Bower, M.D., M.P.H., the program director and OHSU assistant professor of medicine. Learning is tailored to each reentrant's specific practice goals, as determined at the start of the course. Activities can include treating patients under direct supervision and participating in rounds. The program lasts from one to three months based on individual needs.

About a dozen people have completed the program so far, Bower said, with all but one of the those returning to practice and comfortable in their new roles. The program keeps track of how long it takes graduates to find a job and how many job offers they receive. Bower added that the program is developing a follow-up system to assess how well prepared the physician was upon reentry.

Although Bower said reentering physicians can be successful, both she and Mulvey agree that reentering physicians face real challenges. There is no uniform set of resources for physicians seeking reentry, and physicians typically have to develop their own plans before returning to practice. Requirements from licensing boards can vary, be vague, or change over time, Mulvey said.

The PRWP and other stakeholders are working to develop a standard set of guidelines for reentering physicians. The PRWP also is launching the Maintenance in Practice Initiative to provide resources and suggestions for physicians who are leaving the workforce but plan to reenter. The initiative helps doctors remain current on their knowledge and certifications from the outset, rather than having to scramble once they decide to return.

"There's no 'one size fits all' approach, and that's another challenge," Mulvey said. "We need to try to come up with solutions that are not overwhelmingly costly, that will meet a large number of needs, and recognize that this is a very individualized situation."

The American Medical Association's Council on Medical Education in a 2008 report recommended 10 guiding principles for reentry programs. According to the guidelines, reentry programs should be affordable, collaborative, and flexible in their requirements to meet the needs of returning physicians. The report also recommended that physicians who take a leave of absence for an event such as childbirth, but plan to eventually practice again, consider working part time in a shared practice or volunteering at a free clinic to keep skills sharp and reduce or eliminate the need to participate in a reentry program.

Another challenge, Mulvey and Bower say, are that reentry programs can be hard to come by. There are an estimated five programs nationwide, and the cost of these programs can be as high as $30,000. At OHSU, tuition ranges from $5,000 to $10,000 per month, not counting the costs of relocating temporarily for physicians who do not live nearby. Bower said that she never hears back from some physicians who inquire about the program and suspects the main reason is the cost.

There also is no government funding for physicians who want to participate in a reentry program, though funding would be an economical way to increase the physician workforce, Bower said.

"If we have physicians who have been fully trained who would like to come back and practice, even though training them to reenter can be expensive, if you compare it to the total investment of training a physician from the start, it's really much less expensive," Bower said.

(Elissa Fuchs contributed to this article)