

## Q&amp;A

## Don't expect a one-size-fits-all reentry program

*Editor's note: One size doesn't fit all when it comes to physician reentry, and that's the way it should be, according to **Nielufar Varjavand, MD**, associate professor of medicine at Drexel University College of Medicine and program director of the Drexel Physician refresher/reentry course at Drexel University in Philadelphia. What is the current state of reentry? Contrary to some expectations, most of the physicians reentering practice are men. And there aren't that many seeking reentry, she says.*

**Q** Has there been increased interest in Drexel's reentry program?

**A** I would say numbers are steady for the past few years. One of the areas that everyone mentions with reentry is that there's a huge group of physicians that wants to reenter. But there's no data that all of these inactive physicians are rushing back to reenter clinical work.

**Q** How much of a factor is time away from practice? Is that a significant barrier to reentry?

**A** Coming back is quite difficult, or it can be. It's not just time away. When a person leaves, there are so many components: There's what they did before they left, why they left, and why they're coming back. All of these variables play a role in reentry. At the same time, everyone who is practicing needs to have the same up-to-date knowledge and skills. In that case, the reason why someone left or the time elapsed doesn't matter—everyone has to reach the level of current standards and excellence.

If they were “dyscompetent” before they left, then during that time they'll lose more competence. But if they were perfect before they left, who says two years or three years away from practice is going to be a deterrent for them?

**Q** Can you describe what Drexel's reentry program might do for physicians seeking to reenter practice?

**A** We provide education, and we serve not only physicians who've had problems, but [also]

those who've voluntarily left practice. Really, we work with anyone who wants to reenter—if we feel that we can meet their goals.

It depends on why they're here. We try to understand why they're being referred to us, what their needs are, what their goals are; we try to understand their background, what they used to do. We do a pre-assessment to understand where they are in terms of their knowledge and skills.

We combine all of that to work with the trainee in order to develop a program for them that would meet their individual needs as well as the group that has referred them.

Then we provide education and clinical experiences [through] a wide variety of learning exposures. We assess physicians as they go through the program (and at the end) in order to provide summative and formative feedback in order for the physicians to learn and improve.

**Q** When a physician finishes the program, do you then certify or otherwise document that this person is ready to practice?

**A** Upon completion, we write an extensive, detailed letter stating everything the physician has done, everything that they accomplished while they were with us, assessments, and evaluations from the faculty.

If the physician allows us—and 100% of the time they do—we release that letter to whomever they want; i.e., potential employers or boards. In addition to that letter, we give a certificate of completion and we give CME credit if it has been obtained.

If they [have been] referred by another body, they want us to communicate with that other group. So we are in detailed communication with that other group from the start to the end. Because that's what the physician wants.

**Q** Does your program get more self-referrals, or more people who have been asked to come in by others?

**A** There are all sorts of reasons for referrals; they come from state boards, from attorneys, from

employers, and self-referrals. Self-referrals are the largest group.

**Q** Can you talk a little about the differences for male and female physicians leaving practice and then returning?

**A** In general, physicians have left for all sorts of reasons—and they are usually men. However, among the female physician population, it's usually for family reasons. Everyone thinks that returning physicians are women, but that's not the case. Physicians leave and return for all sorts of reasons. But if you only tease apart the women, it's the women who have left for family reasons. That data is pretty consistent.

**Q** What are some of the reasons that male physicians leave practice?

**A** They may be switching positions, may be completely leaving medicine to pursue another line of work, maybe pharmaceutical. But also family, medical reasons, medical disability, and then license problems. There are all sorts of reasons.

That data is also consistent. Our program has been around since 1968, and when they looked at data from 1968 through 1993, it was more men who had taken the reentry program. Various authors reported on the research in the *Journal of the American Medical Association*, *Academic Medicine* [and other publications].


**Q** Does your program encounter physicians who are seeking to reenter practice in a different field that the one for which they trained—i.e., practice drift?

**A** A little bit—there's a small number we've seen. However, I wouldn't see them unless they were referred to us from a state medical board.

Usually, if people come to us saying they want to be retrained to a different field, I don't recommend that. For instance, if someone who was doing primary care wanted to do [obstetrics], that just doesn't make sense. Or if there's a physician who was doing psychiatry and now wants to do primary care, I tell them that's not what's usually done, you're going to have a lot of problems obtaining credentialing, etc.

Usually, people just don't follow up.

**Q** A few years ago, the AMA, Federation of State Medical Boards, and other groups recommended particular components for physician reentry programs. However, there has not been much guidance on this topic from regulators or accreditors since then. Is that an issue?

**A** In the field of reentry, all stakeholders work very well together to collaborate and to keep each other informed. research. 

## Reentry program guidelines

Regardless of the reasons that a physician leaves practice, there are four major components that every reentry program should have, according to the AMA, the Federation of State Medical Boards (FSMB), and specialty societies. These organizations recommend that physicians returning to work do the following:

- Undergo an initial assessment to determine where their knowledge gaps are
- Receive refresher education
- Complete a clinical preceptorship
- Receive a second assessment to determine whether they are competent to return to work

State requirements vary when it comes to physician reentry. The FSMB adopted a Reentry to Practice policy at its annual business meeting in 2012. Subsequently, in its Report of the Special Committee on Reentry to Practice, the federation encouraged state medical boards to develop standardized processes for physicians and physician assistants to demonstrate competence prior to reentering practice after an extended absence.

The report recommended 12 guidelines in five categories:

- Education and communication issues
- Fitness to reenter practice
- Mentoring for practitioners who want to reenter the workforce
- Improving regulation of clinically inactive, licensed practitioners
- Relationship between licensure and specialty certification